

The Primer

FACT SHEETS ON MENTAL HEALTH AND ADDICTIONS ISSUES

• BC Partners for
Mental Health and
Addictions Information
EMPOWERMENT THROUGH INFORMATION

- What are Mental Disorders?
- What is Addiction?
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- Postpartum Depression
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- The Personal Costs of Mental Disorders and Addictions
- Mental Disorders, Addictions and the Question of Violence
- Coping with Mental Health Crises and Emergencies
- Mental Disorders: What Families and Friends Can Do to Help
- Getting Help for Mental Disorders
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What are Mental Disorders?

Like it or not, mental illness can affect anyone. In BC, one in five people will experience some form of mental illness this year, according to research by Health Canada and the Canadian Alliance on Mental Illness and Men-

communities are both at risk of developing mental illness. That said, some people are more at risk for certain mental illnesses than others. For example, men are more likely than women to develop substance use disorders and antisocial personality disorder, which involves aggression, physical assaults and violation of the rights of others. Women are more likely to experience anxiety disorders and depression. Some of the disorders are also more commonly diagnosed than others. For instance, depression and anxiety account for eight out of ten of all psychiatric diagnoses in Canada.

Furthermore, a growing body of evidence reveals an increased risk for mental illness if a person:

- has experienced physical or sexual abuse as a child
- has parents who have, or have had, mental illness
- has not finished high school
- is unemployed
- is receiving public assistance and/or lives in a low-income household

Nevertheless, the absence of these risk factors does not shield a person from mental illness. Again, these disorders can affect anyone.

Mental illness is nobody's fault. It is not the result of bad parenting, emotional weakness or personal failure. Most people with mental illness are productive members of society. They have jobs, relationships, family, hobbies and are active members of their communities.

In order to offer caring support for people with mental illness, it is important to recognize that symptoms of these illnesses are often beyond their control. People with mental illness are unable to just "snap out of it"; they cannot stop their symptoms simply by trying any more than someone with impaired hearing can hear better by trying harder to listen.

Symptoms can range from a depressive mood or a terror of flying to unhealthy eating behaviours or responding to voices that no one else can hear. With some mental illnesses, a person's thoughts and feelings may bounce around inside them, sometimes in disorganized and unpredictable ways. Some people lose interest in daily activities and may appear unwashed and unkempt, while other people with mental illness are able to hide most of their symptoms from others.

Having a mental illness is not the same as being mentally handicapped, or what is now known as a developmental disability. People who are developmentally challenged as a result of a genetic disorder such as Down's Syndrome are born with developmental delays that can affect a person's intellectual development

Facts About Mental Illness

- one in five Canadians has or will develop a mental illness
- mental illness affects a person's thinking, feeling, judgment and behaviour
- mental illness is not contagious or dangerous
- mental illness cuts across age, gender, economic, ethnic and political boundaries
- although there are no cures for some forms of mental illnesses, treatments can reduce the symptoms and help people lead productive and fulfilling lives
- mental illness has a significant biological component
- people with mental illness need caring support; these illnesses can place enormous emotional and financial strains on the person with the illness and their family and friends

tal Health

Some Canadians shy away from people with mental disorders, but in many cases it is not the person with mental illness we fear. Rather, it is our misconceptions about people with mental illness — that they lack intelligence, have nothing to contribute or are dangerous and violent — that unleash our anxieties. The best way to dispel these myths is community-based education, and in some cases, direct contact with people experiencing these illnesses.

Mental illness is a broad term for large categories of mental disorders such as mood disorders, anxiety disorders, schizophrenia, eating disorders, personality disorders, substance use disorders and addictions, and Alzheimer's disease and related dementia. The symptoms of mental illness can be mild, moderate or severe and may appear at different times in a person's life.

Who can mental illness affect? Anyone. People with mental disorders are school teachers, doctors, mechanics, lawyers, homeless people, university presidents, artists and corporate CEOs. Just look around any office, restaurant or public place, and you can be sure that someone nearby is experiencing, or has experienced, some form of mental illness.

City dwellers and people living in remote

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Mental Illnesses vs. Developmental Disabilities

Although a person can have both a mental illness and a developmental disability (what used to be known as a mental handicap), the terms are *not* interchangeable.

Mental illnesses can affect anyone at any age, do not generally affect one's intellectual capabilities, can be treated successfully in most cases, and although they often have a genetic component, are not usually present from birth.

Examples of mental illnesses:

- Depression
- Bipolar disorder
- Anxiety disorders
- Schizophrenia
- Eating disorders
- Personality disorders
- Dissociative disorders
- Dementia
- Attention deficit disorders

Developmental disabilities affect a smaller proportion of the population, are usually present from childhood, are not an illness, are life-long and can affect one's intellectual development and functional capacity in such areas as language, mobility, learning and self-care. The most commonly recognized developmental disabilities are Down's Syndrome and some types of autism. Of course, someone with a developmental disability can also have a co-occurring mental illness.

Examples of developmental disabilities with no intellectual handicap:

- Cerebral Palsy
- Muscular Dystrophy
- Spina Bifida

and functioning in such areas as language, mobility, learning and self-care. In contrast, mental illness can strike at any age, is treatable and may or may not affect a person's intellectual capacity.

As yet, there are no known cures for mental illness. However, as research progresses, new drugs and other therapies are becoming more effective at reducing symptoms of mental illness and restoring a person's quality of life.

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World Mental Health Facts

- number of people worldwide who suffer from mental or neurological disorders: 450,000,000
- number of people with a known, treatable mental disorder who never seek help: 297,000,000
- number of families likely to have at least one member with a mental disorder: 1 in 4
- number of countries (from a total of 191) that currently have no mental health policy: 78
- number of countries that have no mental health program: 69
- number of countries that have no mental health legislation: 37
- number of countries in which treatment of severe mental disorders is unavailable in primary health care: 73
- percentage of countries that allocate only 1 % of their health budget to mental health: 33
- percentage of countries that allocate less than 1 % of their total health budget to mental health: 33
- number of countries that do not have the three most commonly prescribed drugs used to treat depression, schizophrenia and epilepsy: 48
- average number of psychiatrists per 100,000 people in half the countries in the world: 1
- average number of hospital beds reserved for mental disorders in 40 % of the world's countries: fewer than 1

Source: World Health Organization

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What is Addiction?

Addiction commonly refers to harmful pre-occupation with substances like alcohol or behaviours like gambling. Technically addiction is a disorder identified with loss of control, pre-occupation with disabling substances or behaviour, and continued use or involvement despite negative consequences.

With respect to substances, it is often more appropriate to speak of problem substance use. Many people use substances in a way that is not problematic. For instance, having a glass of wine with dinner, once or twice a week, is a way of using alcohol that is not likely to cause them problems. Whether or not use of a substance is problematic depends on many factors, including the substance, the individual, the behaviour involved, and the context.

The problems that can develop with substance use fall on a continuum from mild to severe. Someone who drinks too much alcohol every few weekends in a social situation may experience hangovers, slightly diminished overall health and fitness, and put themselves at increased risk of injury while they are drinking. However if the frequency of excessive drinking increases, they could experience more severe problems such as family difficulties, significant physical symptoms, financial problems, and trouble at work.

Addiction and problem substance use are highly stigmatized, and we hear many misconceptions. Among these are the views that addiction is the result of moral weakness or lack of control, or that it is a purely medical affliction like any other disease, that can be "fixed" by a doctor.

In fact, there are a variety of factors that contribute to problem substance use, and if these factors act together, addiction may develop.

Risk factors for problem substance use include:

- a genetic, biological, or physiological predisposition
- external psychosocial factors such as community attitudes (including school), values and attitudes of peers or social group, and family situation
- internal factors such as coping skills and resources (e.g. communication and problem solving skills)

These factors all influence each other, and the individual's ability to cope with stressful or traumatic events depends on all of them. A degree of rebellion is a normal part of growing up, but a vulnerability in one or more of these areas could lead ordinary experimentation to turn into problem substance use. For instance a child of alcoholic parents whose peer group

Degrees of Use

Substance use falls on a continuum based on frequency, intensity, and degree of dependency.

- **Experimental:** use is motivated by curiosity, and limited to only a few exposures.
- **Social/Recreational:** the person seeks out and uses a substance to enhance a social occasion. Use is irregular and infrequent, and usually occur with others.
- **Situational:** there is a definite pattern of use, and the person associates use with a particular situation. There is some loss of control, but the person is not yet experiencing negative consequences.
- **Intensive:** also called "bingeing," the person uses a substance in an intense manner. They may consume a large amount over a short period of time, or engage in continuous use over a period of time.
- **Dependence:** can be physical, psychological, or both. Physical dependence consists of tolerance (needing more of the substance for the same effect) or tissue dependence (cell tissue changes so the body needs the substance to stay in balance). Psychological dependence is when people feel they need to use the substance in particular situations or to function effectively. There are degrees of dependence from mild to compulsive, with the latter being characterized as addiction.

Source: Kaiser Foundation

approves of substance use, is at increased risk of developing problems arising from substance use. They may observe their parents using alcohol as a coping mechanism, and this behaviour is reinforced by their peer group who does not disapprove of such use. Alternatively, a person who manifests very few of these risk factors may develop problems arising from substance use as a result of a traumatic experience, for instance they could become dependent on prescription drugs following a serious car accident.

Problem substance use can happen to anyone, and is manifested in diverse ways. Sometimes substances are used to escape, for instance a person who has suffered abuse or trauma may find that using a particular substance numbs them to their pain. In other circumstances, using a substance can be normalized by a peer or social group. Then if a person experiences stress related to their work or family situation, the already familiar substance can be used as a coping mechanism.

As well as arising in widely varied circumstances, substance use problems are experienced diversely, not only by the person using the substance. Family members are almost always affected when a spouse, parent, or other relative suffers from problem substance use. Having a boss or employee, or even a rental tenant with a substance abuse problem can be very difficult. The problems that arise from substance use are diverse, and their experience is not limited to the person using the substance.

One of the best ways of trying to avoid problems with substance use is to be informed. Know about the effects and risks that are associated with particular substances. Educate your children about them, to avoid the mystique of the unknown. Many children consider their parents to be the most reliable source of information on drugs, but parents can be reluctant to broach such topics with their kids.

The tendency to develop strong, long-lasting habits is built into every person. This human tendency probably lies at the heart of all addiction. Sometimes, habits are good. Patterns of action that we learn over time and then forget about help us in our daily lives. Some of our

habits are obvious, some are hidden, some are simple, and some are very complex. It is best if we are aware of our potential to form habits, and gain some control over them. We need to build habits that work for us, and avoid or get rid of habits that are not beneficial.

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Know the Facts

Addiction and problem substance use tend to be highly stigmatized, and there is a lot of misinformation around.

- The use of mood-altering substances has been a feature of human societies for thousands of years. Substance use has been regulated in various ways, and it is only in the 20th century that it has been criminalized.
- We all use substances, many of which affect our mood. Whether we eat something that gives us pleasure (such as chocolate), enjoy a glass of wine to enhance a meal, or take a prescribed medication to control pain from a recent injury, the use of substances is an accepted part of life.
- All substances have effects. Some have greater risks. Risk is related to many factors beyond the substance.
- Many people can use substances in moderation (whether legal or illegal), without experiencing problems. Usually when problems arise from substance use, there are a range of other factors at work.
- Binge drinking on the weekend, over-use of prescription drugs, consuming "club drugs" at a rave, drinking more than 5 cups of coffee, and smoking cocaine are all potentially problematic forms of substance use.

Source: Kaiser Foundation

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Depression

Most people have felt depressed at some time in their lives. Feelings of discouragement, frustration and even a sense of despair are normal reactions to loss or disappointment and may last for days before gradually disappearing. In fact, in a 2001 national survey, a quarter of Canadians acknowledge feeling depressed about once a year and another 21 % feeling depressed a few times a year.

But for most of these people, the depressed moods are brief and disappear on their own.

When a case of the "blues" won't pass after a couple of weeks and begins to interfere with work, family and other aspects of life, the low mood is usually a sign of clinical depression.

According to Health Canada and the Canadian Alliance for Mental Illness and Mental Health, approximately eight per cent of adult Canadians will experience a major depression at some point in their lives. Over a six-year period of study (1995-2000), visits to doctors for depression increased 36 % ranking it second only to high blood pressure as the leading cause for visiting a physician; in 2000, that meant nearly eight million consultations with physicians across Canada about depression.

Rates of depression are especially high among Canadian youth. A nationwide survey conducted by the Canadian Mental Health Association and the Canadian Psychiatric Association

found that more than 40 % of people aged 18 to 24 years felt "really depressed" once a month or more. But all ages are affected. In 2000/01, almost 2 million Canadians, 7 % of the population aged 12 or older, had experienced symptoms of depression. BC had the second highest proportions of people with a probable risk of depression in the country (8 %).

"Depression can affect children, seniors and

adult men and women of all socio-economic backgrounds," says Ed Rogers, President of the Mood Disorders Association of BC. The stress of unemployment can make some people more vulnerable to depression, yet many people with depression also have prestigious and highly demanding careers, including former Ontario premier Bob Rae.

Twice as many women as men are diagnosed with depression. However, this may simply indicate that men are less comfortable seeking help or do not get an accurate diagnosis

since depression in men often manifests itself as a substance use problem.

There are two main types of depression: clinical depression (or major depression) and bipolar disorder (also called manic depression). Both illnesses have mild, moderate and severe forms depending on the number and intensity of the symptoms.

During a major depression, a person's gen-

Treatments for Depression and Bipolar Disorder

- with appropriate treatment, more than 80 % of people with depression get full relief from their symptoms or at least substantial improvements
- most people respond to a combination of medication and psychotherapy
- in some cases, electroconvulsive therapy (ECT) may be helpful
- people with mild or moderate depression may benefit from herbal extracts of St. John's Wort (*Hypericum perforatum*)
- light therapy can benefit people with seasonal affective disorder ("winter depression")
- regular exercise and a healthy diet can help lessen overall symptoms
- spiritual faith or practice can give hope
- people with mild depression may benefit from accenting the positive and increasing pleasurable activities

Risk Factors Associated with Depression

Both sexes:

- youth (ages 18-24)
- recent negative life events (e.g. moving, loss of a loved one, family problems)
- divorce
- chronic stressors (e.g. unemployment, illness, care-giving)
- low self-esteem
- a lack of closeness with family and friends
- being single
- having low to moderate self-esteem
- traumatic events (e.g. child sexual abuse, violence, rape)
- family history of mood disorders or addictions

People Who Are Either Known or Believed to Have Suffered from Depressive Disorders

Edwin "Buzz" Aldrin	Ann-Margaret	Alexander the Great
Hans Christian Anderson	Ludwig von Beethoven	Irving Berlin
William Blake	Napoleon Bonaparte	Marlon Brando
Barbara Bush	Jim Carrey	Virginia Woolf
Winston Churchill	Dick Clark	Oliver Cromwell
Sheryl Crow	T.S. Eliot	Queen Elizabeth I
F. Scott Fitzgerald	Thomas Jefferson	Sigmund Freud
Ernest Hemingway	Audrey Hepburn	Margot Kidder
Abraham Lincoln	Elizabeth Manley	Michelangelo
Sir Isaac Newton	Florence Nightengale	Georgia O'Keefe
Dolly Parton	Ezra Pound	Theodore Roosevelt
King Saul	Charles Schultz	Alfred, Lord Tennyson
Mark Twain	Vincent van Gogh	George Washington

Source: The Society for Depression and Manic-Depression of Manitoba, Inc.

eral outlook on life can shift dramatically. It can lower a person's sense of self-worth and change how they feel about friends and family. In some cases, the habits of a lifetime may be set aside, replaced by a feeling of complete apathy.

Since depression affects the whole body, it can alter eating and sleeping patterns, increase restlessness and overall fatigue, and even cause mysterious symptoms of physical illness. Disabling episodes of depression may occur many times or only once, twice or several times in a lifetime.



Jane, a 30-year-old biologist who didn't want to use her real name, says that during her depression, she felt hopeless and unable to experience joy and happiness. "I felt like I was living in my own separate reality from everyone else," she says. "At the worst it was the negative feelings that completely took over."

Jane was diagnosed with seasonal affective disorder or "winter depression." Up to 120,000 people in BC may experience clinical depression in the winter because of the shorter day lengths, according to the Mood Disorders Clinic at the University of British Columbia. Nevertheless, people with winter depression report significant relief with as little as 30 minutes a day of sitting under a lightbox which provides bright, artificial light.

Bipolar disorder is a less common form of depression that affects about one to two per

cent of Canada's population. This illness involves cycles of depression alternating with a "high" known as mania. Sometimes the mood swings are dramatic and rapid, but more often they are gradual.

During the depressive phase of the cycle, people may experience any or all of the symptoms of a clinical depression. In contrast, the manic phase may bring excessive energy, racing thoughts, inflated self-esteem, rapid changes in emotions and impulsive behaviour such as buying sprees or sexual indiscretions.

A variety of biological and environmental factors can increase a person's risk of developing bipolar disorder or depression. For example, stress related to work, relationships, and finances can trigger a depressive episode. At times, prolonged illness can bring on depression. In many cases, especially with bipolar disorder, depressive illnesses can be traced to genetic factors.

One's general attitude towards everyday life may also play a major role in depression. Traits such as dependency, perfectionism, low self-esteem, difficulty expressing unwanted feelings and inadequate coping skills tend to make a person more susceptible to depression.

This information is useful from a prevention and treatment perspective since many ideas and approaches to life can be changed with practice and caring support, notes the CMHA. For example, cognitive therapy is based on the idea that people can alter their emotions and even improve their symptoms by re-evaluating their attitudes, thought patterns and interpretations of events.

More than 80% of people who get adequate treatment for depression experience full relief from their symptoms or at least will improve substantially. Bipolar disorder is often a recurring condition, but with a combination of medication and psychotherapy, many people with this illness can return to work and continue to enjoy all of life's pleasures.

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Depression and Substance Use

There is a strong, entwined relationship between substance use and depression. This relationship has a variety of components. It is common for people experiencing depressive symptoms to self-medicate with the use of drugs or alcohol. These individuals may not be aware that depression is present, but they do recognize that they feel better, at least in the short term, when they use a substance.

There are certain drugs that by their very nature can create symptoms of depression. Alcohol, for example is a central nervous system depressant. People who consume alcohol report a higher level of depressive symptoms than non-drinkers. The experience of depression also typically increases with the increased use of alcohol.

Conversely, depressive symptoms are also common when people are in withdrawal from substance use. Cocaine for example, is a stimulant. Using cocaine releases dopamine and serotonin in the brain, our bodies' "feel good" chemicals. Over time, however, the body loses its ability to release dopamine properly, and depression results from cocaine use instead.

The other area of interaction between drug use and depression can occur when a person stops using drugs or alcohol completely. Following the acute withdrawal period, there occurs a post-acute withdrawal period, which typically lasts from 6 months to two years, depending on the substance use history and the person's stress level. During this time, the brain is repairing itself from the damage of alcohol or drug use, and oftentimes, symptoms of depression are experienced.

When someone has been using drugs or alcohol, it can be difficult to determine the origin of the depressive symptoms the person may report experiencing. Treatment however, whether depression is clinically present, or present due to drug or alcohol use is essentially the same. Over time and with ongoing evaluation, the nature of the depression can be better ascertained.

Hope. Geneva: WHO, 2001. Accessed 7 January 2003. Available online at www.who.int/whr2001/2001/

Wowk, Linda G., et al. *Who Turned Out the Lights: A Guide For Families Who Have a Relative with a Mental Illness*. Vancouver: Canadian Mental Health Association, BC Division, 1993.

Worldwide Depression Stats

- number of people worldwide suffering from depression: 121,000,000
- the 4th leading cause, worldwide, of life years lost due to disability: depressive disorders (behind infectious diseases, heart disease and respiratory infections, and before HIV/AIDS)
- the ailment expected to rank 2nd in global diseases, after heart disease, by 2020: depressive disorders
- the mental disorder most commonly leading to suicide: depression

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Bipolar Disorder

We all experience shifts in our mood: some days we feel happy and ready to take on the world; other days can be discouraging, filled with sadness and frustration. Our emotional state of being varies constantly, and can fluctuate between these two extremes on a daily basis.

Although some fluctuation in mood is normal, when it becomes so extreme that the person feels like their mood state shifts through low and high periods, this can indi-

Symptoms of Depression

- feeling worthless, helpless or hopeless
- sleeping more or less than usual
- eating more or less than usual
- having difficulty concentrating or making decisions
- loss of interest in taking part in activities
- decreased sex drive
- avoiding other people
- overwhelming feelings of sadness or grief
- feeling unreasonably guilty
- loss of energy, feeling very tired
- thoughts of death or suicide

Symptoms of Mania

- excessively high, elevated or irritable mood
- unreasonable optimism or poor judgement
- hyperactivity or racing thoughts
- talkativeness, rapid speech (sometimes becoming incoherent)
- decreased sleep
- extremely short attention span
- rapid shifts to rage or sadness

cate the presence of bipolar disorder.

Bipolar disorder, formerly known as manic-depression, is a form of clinical depression that affects 1 to 2% of the population in a lifetime or about one in every five people with mood disorders. It does not discriminate among socioeconomic groups and, unlike other kinds of depression, seems to affect men and women equally. What *can* elevate your risk though — by about 15% — is being the close relative of someone with the disorder.

Robert Winram, who has lived with bipolar disorder since he was a young adult, says that for him, receiving the diagnosis was a very important first step. "For 25 years, I had no diagnosis, and didn't understand what was happening. It was a great relief to finally know what it was," he says.

The experience of bipolar disorder from

person to person depends on how fast the individual moves through periods of depression and mania, how severe each extreme gets, and what else happens during each state (for instance, whether the person experiencing psychosis, or a break with reality, during mania or depression.)

Despite these differences, an episode of bipolar disorder will feature a person experiencing cycles of moods, including periods of depression, normal mood and mania. Depressive symptoms are similar to those experienced by people undergoing a major depression. During this time, a person can feel a range of bodily symptoms affecting sleep, appetite, concentration and energy levels and a range of psychological symptoms including worthlessness, helplessness, hopelessness and apathy.

In contrast, a person in a manic phase may suddenly experience an excessively high or elated mood. They may begin to talk rapidly, have little need for sleep, make grandiose plans and even start to carry them out. Such uncharacteristically risky or ambitious behaviour can sometimes land the person in trouble. For example, someone may spend money very freely and get into debt, or show disregard for the law. They may also show an uncharacteristic lack of judgement in their sexual behaviour. And as already mentioned, some people also have psychosis (e.g. delusions and hallucinations) during this time.

For Robert, the mania would manifest itself as loss of sleep, fatigue, cold sores, and fast speech. "I would become overly busy, impulsive, talkative and take on too many projects," he says. "Eventually, my thinking became so muddled that I started having delusions and became paranoid that I was seeing signs directed at me. For example, I thought that my neighbours were watching me and that newspaper articles or advertisements had special meanings meant just for me."

Although the illness can first strike at any age, it is most commonly developed in young adulthood, especially in one's 20s. Many people with the illness take years to be properly diagnosed because doctors often only see the patient when they are depressed and may fail to ask the right questions to diagnosis bipolar disorder.

Bipolar disorder can take a mild, moderate or severe form depending on the number and intensity of the symptoms. Though people may struggle with the illness for many

years, an episode itself is never permanent, lasting from several days to a number of months. With professional treatment, however, it may end much more quickly.

There are a number of possible causes of bipolar disorder. Biochemical factors are thought to play a large role. Since a person's risk of developing bipolar disorder increases if they have a close relative with the disorder, genes are thought to play an important part too. In addition, stress related to work, relationships, finances and other areas of life can trigger a bipolar episode.

Medications can often help to reduce, if not stop, the extreme mood swings associated with manic depression. Psychological therapy and the support of family, friends, support groups and other self-help strategies can also help people to lead fuller and more active lives.

Robert's diagnosis gave him much insight into his illness and enabled him to seek appropriate treatment. He found effective medication and began to learn how to manage the illness. He recently retired as the Executive Director of the Mood Disorders Association of BC. "I find my work both difficult and empowering, as it teaches me that I am no longer a victim and allows me to use my experiences to reach out to others so that they can begin their own paths to recovery."

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Celebrities with Bipolar Illness

A partial list of public figures who have made public their experiences with manic depression:

- Buzz Aldrin, astronaut
- Ned Beatty, actor
- Danny Bonaduce, radio personality, actor, writer
- Robert Boorstin, writer, special assistant to President Clinton, State Department
- Tim Burton, artist, movie director
- Dick Cavett, writer, media personality
- Rosemary Clooney, singer
- Francis Ford Coppola, director
- John Daly, athlete (golf)
- Robert Downey, Jr., actor
- Kitty Dukakis, former First Lady of Massachusetts
- Patty Duke, actor, writer
- Thomas Eagleton, lawyer, former U.S. Senator
- Carrie Fisher, writer, actor
- Larry Flynt, magazine publisher
- Connie Francis, actor, musician
- Kaye Gibbons, writer
- Linda Hamilton, actor
- Margot Kidder, actor
- Bill Lichtenstein, producer (TV & radio)
- Kristy McNichol, actor
- Dimitri Mihalas, scientist
- Spike Milligan, comic actor, writer
- Robert Munsch, writer
- Ilie Nastase, athlete (tennis), politician
- Jimmie Piersall, athlete (baseball), sports announcer
- Charley Pride, musician
- Axl Rose, musician
- Scott Simmie, writer, journalist
- Darryl Strawberry, athlete (baseball)
- Gordon Sumner (Sting), musician, composer

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Postpartum Depression

Childbearing is a special time in a woman's life — a time of changes, both physical and emotional. During pregnancy, her body changes, her hormones are in flux, and she has to come to terms with the joys and responsibilities of a new life growing inside of her. After childbirth, she still has to deal with her own changes, but now has to take care of her baby's needs as well.

What Does it Look Like?

Symptoms of postpartum depression can include:

- Crying for no apparent reason
- Numbness
- Feelings of helplessness
- Frightening thoughts or fantasies
- Over-concern for the baby
- Depression that may range from sadness to thoughts of suicide
- Anxiety or panic attacks
- Feelings of inadequacy or inability to cope
- Sleeping problems
- Changes in appetite
- Feelings of resentment towards the baby or other family members
- The feeling that something is not right

Source: Pacific Post Partum Society

While childbearing is usually marked with celebration, families and the broader community may forget that this can be a stressful time for a mother perhaps overwhelmed with all the sudden changes and stressors in her life. Sometimes, the experience can be so disorganized and exhausting that the woman becomes too sad, anxious or overwhelmed to get back to her normal life. This can be a sign of postpartum

depression, notes the CMHA.

Postpartum depression is a form of clinical depression that affects 12 to 16% of mothers. In lasting weeks, months or even years after birth, postpartum depression distinguishes itself from the fleeting "baby blues," a common feeling of distress and tearfulness that usually disappears within the newborn's first weeks of life.

Postpartum depression is not restricted to women who are giving birth for the first time, either. It is just as likely to affect women who are adopting, and those who have had children before. Moreover, it can occur anytime from right after childbirth, to a few months later. Ten per cent of women will begin to have symptoms during pregnancy.

The symptoms of the illness include feelings of helplessness, numbness, and depression. The woman often feels a lack of control over her emotions, sometimes crying for no obvious reason, or having a panic attack.

Also, it is common for women with postpartum depression to feel inadequate or unable to cope with their new responsibilities. The woman might be overly concerned about the baby, feel anxious, irritable, worry excessively, have difficulty sleeping or feel resentment towards the baby or other family members. This, in turn, can make her feel guilty for having these kinds of emotions.

Sometimes women experience frightening and upsetting thoughts about harming their babies even though this is not something they would ever want to do. These thoughts are quite common with postpartum depression; many women experience them and do not act on them. In some very rare cases where a mother does harm her baby, she is usually experiencing psychosis, that is to say, she's out of touch

How Women Can Help Themselves

- Get some sleep
- Spend some time away from your baby and try not to feel guilty about it — you deserve some "me time" too
- Find ways to nurture yourself while with your other children — even two minutes with your feet up can be helpful
- Look after yourself (e.g. eat well, exercise)
- Accept yourself and your feelings
- Pay attention to the good feelings
- Find support from family members and other loved ones

How Dads and Other Supporters Can Help

- Encourage her to talk to you about how she feels
- Tell her you love her and are there for her
- Share in home responsibilities
- Accept help from friends and family
- Be physically affectionate, but don't push for sex until she's ready

Source: Pacific Post Partum Society

Reproductive Mental Health Issues

Beyond the postpartum period, other times in a woman's reproductive life cycle when mental health can undergo enough stress and change that sometimes intervention is needed include:

- pre-menstrual period
- before, during and after menopause
- pregnancy
- miscarriage or stillbirth
- infertility

with reality. Postpartum depression affects 1-2 women out of 10, while postpartum psychosis affects 1-3 women out of 1000, and even women with postpartum psychosis very seldom harm their children. The risk of a mother with postpartum depression actually harming her child, even when she has frightening thoughts, is extremely low.

Linda King experienced severe postpartum depression with all of her three sons. Although she didn't think to seek help the first time, the births of her second and third sons presented a lot more anxiety and propelled her to seek help.

"There was a lot of fear," she says. "I would have images of something bad happening to my children or my husband. For example, I would be overly afraid of falling down the stairs with my baby. I felt very vulnerable as well. With my first son, my self-esteem was in really bad shape, yet on the outside, I appeared to have it all together. Only later did I learn that often, the better things look to outsiders, the worse the situation may actually be for the mother."

There are many different factors that contribute to postpartum depression. A woman already vulnerable to depression or anxiety, or who has had episodes of depression or anxiety in her lifetime is at greater risk of having pregnancy and childbirth trigger another episode. Some research suggests that hormonal changes related to giving birth may cause the depressive episode. However, this alone cannot account for all postpartum phenomena since we can find it in adoptive mothers as well as mothers several months after childbirth. Some fathers will also experience emotional distress.

Stress certainly plays a major role in the development of the illness. A new baby brings new challenges. For instance, a finicky, colicky, or easily-

agitated baby can cause a lot of worry and anxiety.

It is still not uncommon for a woman to think or be told that breastfeeding causes postpartum depression. While breastfeeding can be very stressful — particularly in the wake of hormonal changes and possible feelings from the mother that she is "failing" at it — it can also be a time when she feels a connection with her baby. The decision to nurse is a very personal choice and probably best made on grounds other than depression; deciding to quit nursing rarely results in relief from depressive feelings.

In a mechanism similar to the development of depression before, during or after Christmas or Valentine's Day, societal views about what you *should* feel and how you *should* behave can conflict with a mother's lived experience and contribute to depression. For example, the "motherhood myth" tells us that mothers should always appear happy, radiant and serene. A new mother is supposed to have infinite love, protection and tenderness for her child. All these expectations can put added pressure on a woman. In fact, it can make her feel even worse if she doesn't appear this way to society.



Photo Courtesy of Health Canada

It is important for women with postpartum depression to develop a support system for themselves. They can do this through family members, support groups, babysitters, day-care and self-care. Many women find it healing to support other women who are going through postpartum depression.

When the birth of Linda's third son brought about the same depressive symptoms, this time she knew about organizations like the Pacific Post Partum Society and decided to seek help from them.

"I received gentle, nurturing support, and was reminded that I was important too," she says. "I didn't receive any messages that I should be so happy about childbirth. Rather, I received more understanding, from people who knew exactly how I felt and believed me."

Linda is now a Postpartum Counsellor at the Society, and she believes that she has benefited a lot from her experience with postpartum depression as well. "I got to know myself much better and have found a lot of coping skills. It has also enabled me to have a better relationship with my children. I now have a much more open mind. I feel this is really spiritual work I am doing, and it has allowed me to meet lots of people and share and learn from their stories."

Some women find that taking antidepressants or other medications may help; however, it is important to work closely with the prescribing doctor so that any possible effects on the fetus, child, or pregnant or nursing mother can be accounted for and monitored. There are newer classes of antidepressants that are considered safe to use while pregnant or breastfeeding.

However a woman decides to seek help for herself, it is important to remember that this is a personal choice. Although postpartum depres-



sion may seem like a never-ending struggle at first, women can and do recover and are able to find fulfilment with their children.

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Pacific Post Partum Support Society. *Postpartum Depression and Anxiety: A Self-Help Guide for Mothers*. 4th edition. Vancouver: PPPSS, 1997.

BC Reproductive Mental Health Program. "Emotional Disorders in the Postpartum Period." Accessed 7 March 2003. Available online at www.bcrmh.com/disorders/postpartum.htm

Facts about Postpartum Depression

- The most vulnerable time for a woman to develop onset of mood disorders is during the postpartum period.
- Adolescent mothers will experience depression more frequently.
- A diagnosis of depression may be missed in the postpartum period because of the demands of caring for a new infant. Changes in sleep, appetite, fatigue and energy are common in both the normal postpartum period and postpartum depression.
- Approximately 30% of women with a history of depression prior to conceiving will develop postpartum depression.
- Approximately 50% of women with a history of postpartum depression will develop postpartum depression in a subsequent pregnancy.
- Emotional disorders during the postpartum period can occur;
 - during labour and delivery
 - within a few days or weeks of delivery
 - most frequently starting within 6 weeks of delivery or
 - at any time up to one year following the birth.
- Due to increased awareness about mood disorders in the postpartum period some more vulnerable women are being diagnosed and treated during pregnancy

Source: BC Reproductive Mental Health Program

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Seasonal Affective Disorder

For centuries, poets and writers have drawn parallels between the weather and mood — and for good reason. We all know how the weather affects what we wear, how we travel, what we choose to do, and how we feel.

When weather affects us to such an extent that we begin to have trouble functioning as usual, however, this can become more than just a case of the “winter blahs,” according to the CMHA.

Seasonal affective disorder, or SAD, is a type of clinical depression that appears at certain times of the year. It usually starts with the shortening days of late autumn and lasts through the winter. However, the term “winter blues” can be misleading; some people have a rarer form of SAD which is summer depression. This condition usually begins in late spring or early summer.

Since the days of winter get shorter the further north you go, SAD has been found to be more common in northern countries. In Canada, about 2 to 3 % of the general population will experience SAD in their lifetime. Another 15 % of Canadians will experience a milder form of SAD where they simply have the “winter blues.”

According to Dr. Raymond Lam, Professor of Psychiatry at the University of British Columbia (UBC) and SAD specialist at UBC's Mood Disorders Clinic, SAD can be debilitating, preventing healthy people from functioning normally. “It may affect their personal and professional lives and seriously limit their potential,” he says. “Many people may be suffering unnecessarily — unaware that SAD exists or that help is available.”

For two decades, David Wu, 32, a registered acupuncturist living in Richmond, struggled with physical and emotional fatigue throughout fall and winter. He had seen many doctors and tried many medications before finally being diagnosed with SAD in 2000, after a suicide attempt from the debilitating depression landed him in hospital. “I had an overwhelming impulse to

end my life,” says Wu.

When a person is going through an episode of SAD, their symptoms may be similar to those of a person going through a depressive episode. This can make it difficult to diagnose. Even physical conditions, such as thyroid problems, can look like SAD. One of the most common symptoms of SAD is a change in appetite. Often, the person gets cravings for sweet, starchy, or other carbohydrate-rich foods. This can result in

Tips to Ease your Symptoms

The following suggestions may help ease or even prevent SAD symptoms from becoming debilitating or be helpful by themselves for those of us with mild symptoms of the “winter blues”:

- spend more time outdoors during the day and try to arrange your environments (and schedules if you can) to maximize sunlight exposure
- keep curtains open during the day
- move furniture so that you sit near a window or, if you exercise indoors, set up your exercise equipment by a window
- install skylights and add lamps
- build physical activity into your lifestyle preferably before SAD symptoms take hold since physical activity relieves stress, builds energy and increases both your physical and mental well-being and resilience
- make a habit of taking a daily noon-hour walk
- when all else fails, try a winter vacation in sunny climates — if the pocketbook and work schedule allow — although keep in mind that the symptoms will recur after you return home. When back at home, work at resisting the carbohydrate and sleep cravings that come with SAD.
- as for other kinds of clinical depression, for those more severely affected, antidepressant medication and/or short-term counselling (particularly cognitive-behavioural therapy) may also prove to be helpful.

overeating and weight gain. People with SAD are often tired all the time, tend to oversleep, and can sometimes feel anxious and desolate as well. Some people may even have suicidal thoughts.

Changes in appetite, according to Dr. Lam, are indicative of the seasonal pattern of the illness. “With initial winter episodes, patients lose the weight during the summer months when their appetite returns to normal and they are more active,” he says. “However, with increasing age it becomes more difficult to shed the winter weight gain, and there is a gradual year-round increase in weight.”

Although SAD may affect some children and teenagers, it tends to begin in people over the age of 20. The good news is that the risk of SAD decreases with age. Like some other depressive disorders, SAD is more common in women than

Advice on Light Devices

Although light therapy is effective for SAD, researchers still do not fully understand how the light works and what is the best method for light therapy. There are now many light therapy devices available on the market making claims about light treatment, but light therapy devices are not well regulated in Canada. Therefore, it's wise to be cautious about recommending light therapy devices and think about the following four principles:

- 1 the light device should be tested and found effective in scientifically-valid studies
- 2 the light device should have a filter that blocks harmful ultraviolet rays
- 3 the light device should be CSA approved for use in Canada (UL means approved for use in the US)
- 4 the light device company should have a track record of reliability

Fluorescent light boxes are recommended because they have been extensively tested with the greatest evidence for effectiveness in scientific studies. Other light devices, for example light visors and dawn simulators, may be beneficial for some patients, but there is less evidence for effectiveness compared to light boxes.

For a list of stores and companies that sell light boxes throughout BC and Canada, visit www.psychiatry.ubc.ca/mood/sad
Source: UBC Mood Disorders Clinic

in men.

Remember though that self-diagnosis or treatment of SAD is not recommended because there are other medical causes for depressive symptoms, and because light therapy may be harmful to people with certain medical conditions (for example, eye disease). See your doctor first.

Research on SAD is still in its early stages. However, it is likely that SAD may be caused by a lack of daylight. Each of us has an internal "biological clock" that regulates our routines, a wake-sleep and active-inactive cyclical routine called a circadian rhythm. This biological clock responds to changes in season, partly because of the differences in the length of the day. For many thousands of years, the cycle of human life revolved around the daily cycle of light and dark. We were alert when the sun shone; we slept when our world was in darkness. The relatively recent introduction of electricity has relieved us of the need to be active mostly in the daylight hours. But our biological clocks may still be telling our bodies to sleep as the days shorten. This puts us out of step with our daily schedules, which no longer change according to the seasons.

One useful way to combat this is to use light therapy, also known as phototherapy. This can be done using a fluorescent light box, a device now available in a variety of safe, economical and portable designs. What they all have in common is they all give out bright, artificial rays that mimic sunlight.

According to the Mood Disorders Clinic, people with seasonal depression during the wintertime report significant relief after using the light box for about 30 minutes a day. Although phototherapy can produce side effects, these are usually mild experiences of nausea, headaches, eye strains or feelings of edginess that go away after using the lightbox for some time.

However, people with certain medical conditions or who are taking certain medications should have special eye examinations before considering light therapy.

Light therapy and other types of therapy for depression have been found to be effective for many people with SAD. Even people with severe symptoms can get rapid relief once they begin treatment, so that when the seasons change, their mood doesn't have to.

Lifestyle changes also help. Wu says his diagnosis was a turning point, and he knows he needs more than light therapy, medication and counselling to keep his depression at bay. "I make a point of keeping a busy schedule, doing a lot of physical exercise and talking to supportive friends," he says. "I do things that give me joy, like singing in a choir and volunteering one morning a week at a local preschool." Wu also swims, practises martial arts and escapes to sunnier climates when he can. "I know I'm vulnerable," he says. "I have to take care of myself."

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Anxiety Disorders

It can drive us to be creative under pressure, warn us of danger or spur us to take action in the face of a crisis. It can also freeze us in our tracks. But like it or not, anxiety is an intense state that most Canadians experience from time to time.

Anxiety affects us physically, emotionally and in all aspects of our life situations, according to the Anxiety Disorders Association of BC (ADABC). Normally,

Do I Have an Anxiety Disorder?

- I am often startled by the smallest thing
- I worry that something terrible will happen to me or others
- I am easily irritable
- I get sudden fears of dying or doing something out of control
- I often worry that something has not been done correctly even though I know I completed the task properly
- I am extremely worried about disease (e.g. germs, infections, dirt, dust, contaminants, cleanliness)
- I need constant reassurance
- I often find myself doing things repeatedly (e.g. hand washing, showering, tooth brushing)

it plays an important role in survival. When we encounter a threatening situation, our bodies prepare for danger by producing more adrenaline and increasing the blood flow and heart rate, among other things. This instinctive "fight or flight" response can help a person survive a physical attack or an earthquake, for example.

Nevertheless, most modern "dangers" such as unemployment are not ones a person can fight with their fists or run away from. With no outlet for release, the body may remain in a state of constant mental and physical alertness that can be extremely draining over the long term.

When anxiety persists for weeks and months, when it develops into a relentless sense of dread or starts to interfere with a person's daily life, then anxiety has moved beyond the realm of ordinary anxiety, according to ADABC.

"A person with this degree of anxiety may require outside help to feel safe in the world again," says Elen Alexov, ADABC President.

Emotionally, people with anxiety may feel apprehensive, irritable, or constantly afraid that bad things will happen to them and people close to them. Depending on its intensity, anxiety can make people feel trapped in their homes, too frightened to even open the door.

Anxiety is the most common form of mental disorder, affecting 12% of the population in any given year. Besides general anxiety, described above, anxiety can take many forms. Major types of anxiety

disorders include phobias, panic disorder, obsessive-compulsive disorder, social anxiety and post-traumatic stress disorder.

A number of different factors can increase the risk of developing an anxiety disorder including past experiences, learned behaviours (e.g. avoidant coping style) and a genetic predisposition, to name a few. There is not one single cause and it is usually a combination of these types of risk factors that lead to the onset of an anxiety disorder for any one individual.

Sometimes anxiety exists alongside other mental disorders such as depression and bipolar disorder. When this happens, a person's abilities are more impaired by illness and the risk of suicide increases dramatically. For example, a 1999 study found that although more than a quarter of people with anxiety disorders reported having made a suicide attempt at some time in their lives, the greatest risk for suicide was the co-existence of their disorder with another mental illness such as depression, schizophrenia or an addiction.

Panic attacks involve a sudden onset of intense apprehension, fear and terror, as well as feelings of impending doom. These attacks may cause shortness of breath, rapid heartbeat, trembling and shaking, a feeling of disconnectedness from reality and even a fear of dying. Though they last only a short time, panic attacks are frightening experiences that may increase in frequency if left untreated.

People with phobias have overwhelming feelings of terror or panic when confronted with a feared object, situation or activity. Many phobias are common — such as a fear of enclosed spaces, airplanes or fear of spiders or snakes — and have a specific name.

For example, people with *agoraphobia* feel terrified of being in crowded situations or public places, or any situation where help is not immediately available. Their anxiety may become so intense that they fear they will faint, have a heart attack or lose control. These people often avoid any situation in which escape may be difficult (e.g., in an airplane), impossible or embarrassing. In some cases, people with agoraphobia may become house-bound for years.

Obsessive-compulsive disorder is another type of anxiety disorder. A compulsion or compulsive act becomes a way of coping with the anxiety created by an obsession, which is a recurring unpleasant thought. For example, a recurring thought such as "I am dirty" may lead to repeated acts of hand-washing as a means of dealing with the obsession and the resulting anxiety. Washing one's hands provides a momentary respite from the anxiety of the obsessive thought, but since the relief is usually short-lived, the compulsive behaviour is often repeated over and over. People caught in this cycle may wash their hands repeatedly until the skin is rubbed raw.

Other compulsive acts include repeatedly checking that a door is locked or that a stove is switched off. Common obsessions include recurring thoughts

Body Relaxation Technique

Use this exercise to relax whenever you need to. Many people also find it helpful before falling asleep:

- breathe slowly and deeply, making your abdomen rise and fall with your breaths
- tighten your foot muscles, curling your toes, and hold for as long as you can
- then release, feeling the warm sensation as your muscles loosen
- repeat with your calf muscles, then work up through the rest of the body
- end by tightening your forehead and scalp muscles
- as you release your body tension, release all thoughts

Source: BC Medical Association

of specific images, numbers or words.

Some people who have survived a severe and often violent physical or mental trauma may have a sense of reliving the trauma many years later. They may develop post-traumatic stress disorder, which involves re-experiencing traumatic events such as a car crash, rape or a life-threatening robbery through nightmares, night terrors or flashbacks.

Among the symptoms of post-traumatic stress disorder are numbing one's self emotionally, experiencing an overall sense of anxiety and dread or feeling plagued by guilt about one's own survival. War veterans are particularly vulnerable to this form of anxiety which can affect one's memory and ability to concentrate and sleep.

Though people with clinical anxiety often feel trapped in a cycle of fear, anxiety disorders are among the most successfully treated forms of mental disorder, according to ADABC. Many people benefit from cognitive-behavioural therapy which is

based on the idea that people can alter their emotions and even improve their symptoms by re-evaluating their attitudes, thought patterns and interpretations of events. An effective treatment plan may include medication, self-help groups, and relaxation techniques. Also beneficial is education about the nature of anxiety, its effects on the body and the role it can play as part of a healthy survival instinct. With time, most people can learn to identify the early signs of a fear episode and manage their symptoms before they develop into full-blown anxiety.

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Tips for Talking to Your Doctor

The average patient asks only two questions during an entire medical visit lasting an average of 15 minutes. However, studies demonstrate that patients who are actively involved in decision-making are more satisfied, have a better quality of life and have better health outcomes. Since most people's treatment path for a mental disorder begins in the family doctor's office, below are some tips for empowering yourself and starting a conversation about disabling anxiety in your life:

- Plan — Think about what you want to tell your doctor or learn from your doctor today. Once you have a list, number the most important things.
- Report — When you see the doctor, tell your doctor what you want to talk about during your visit.
- Exchange Information — Make sure you tell the doctor about what's wrong. Printing out an online screening tool (e.g., www.freedomfromfear.org), or bringing a diary you may have been keeping can help. Make sure to include both physical and emotional symptoms. Sometimes it can help to bring a friend or relative along for support and to help describe your behaviour and symptoms if you're unable to.
- Participate — Discuss with your doctor the different ways of handling your health problems. Make sure you understand the positive and negative features about each choice. Ask lots of questions.
- Agree — Be sure you and your doctor agree on a treatment plan you can live with.
- Repeat — Tell your doctor what you think you will need to do to take care of the problem.

The Anxiety Disorders Association and the BC Mental Health Information Line can also give you a list of possible places for referral that you could suggest to your doctor. If you want to find a new family doctor, the College of Physicians and Surgeons of BC can provide you with a list of doctors accepting patients in your area.

Source: Bayer Institute P.R.E.P.A.R.E Patient Education Program

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Obsessive-Compulsive Disorder

There are times when we find ourselves thinking about something constantly. We may day-dream about someone or something, get a catchy tune stuck in our heads, or worry that we forgot to turn off some appliance in the house before going on vacation. Or we may have a "lucky" sweater that we wear because we believe it may help us win a game or pass a test.

Worry, doubt and rituals like these have a definite presence in our lives. However, when such thoughts and their consequences begin to intrude upon our day-to-day functioning, causing us great distress, anxiety, guilt and shame, this may be a sign of something more serious: obsessive-compulsive disorder.

Obsessive-compulsive disorder, or OCD, is one of several types of anxiety disorders that collectively affect about 12% of people in any given year. Anxiety disorders are the most common of all mental health problems. They affect a person's behaviour, thoughts, emotions, and physical health. Fortunately, they are diagnosable and treatable.

As its name suggests, this type of mental illness is made up of two components: obsessions and compulsions. Obsessions are unwanted and distressing thoughts, ideas, images or impulses that occur over and over again, while compulsions are the associated behaviours or rituals that occur in reaction to the obsessions. A lot of us have habits or occasional rituals, but ritualistic thinking is exaggerated in OCD: people often think harm will come to them or their loved ones if they don't engage in these safety-ensuring rituals.

For instance, a person may be obsessed

with the fear that they may fall ill or die due to contamination from germs. As a result, they may begin cleaning and disinfecting excessively, checking their body for signs of abnormalities, or constantly washing their hands — often to such an extent that the palms become very dry and bleed.

Obsessions are persistent, intrusive, and cause the person much distress and discomfort; compulsions, therefore, are carried out in a bid to reduce these anxious, guilty or shameful feelings. Compulsive actions usually do result in a sense of temporary relief — until the ritual is concluded, of course, and the obsessive thoughts begin again in another vicious cycle of anxiety.

Jim Dutta knows this cycle all too well. "My compulsions were faulty coping mechanisms for my obsessions," he says. "I would reorganize my room, vacuum, and find other ways to get rid of clutter with the irrational thought that somehow, harm wouldn't come my way if I did these things. In school, I was constantly rewriting notes word for word just so there were no mistakes in my notepad. Otherwise, I couldn't perform."

OCD will affect about 1.5% of the population in a lifetime. In childhood OCD, male sufferers outnumber females by a ratio of 3 to 2, but OCD in adulthood seems to affect men and women equally. Although it usually begins during adolescence or early childhood, it can occur at any age, but generally appears before a person reaches 40. According to the National Institute for Mental Health in the United States, at least a third of adult OCD is reported to have begun in childhood.

Although the exact causes of OCD are still being researched, cognitive-behavioural therapy has been shown to be the most effective treatment for the disorder. Therapeutic techniques include exposure and response prevention which involve encouraging a person to stay in contact with the object or situation that forms the obsession, while learning not to perform the ritual to ease the pressure of the obsession.

Cognitive-behavioural therapy works because it attempts to change faulty beliefs associated with OCD and expose the individual to the problem situations, in order to bring about the obsession, while discouraging the compulsion. This has

Common obsessions revolve around:

- Fear of contamination
- Concerns about the illness or body
- Need for symmetry
- Disturbing sexual or religious thoughts
- Aggression

Common compulsions include excessive:

- Washing
- Checking and double-checking
- Touching
- Arranging
- Ordering
- Counting
- Asking for reassurance
- Hoarding (an inability to throw away useless junk)
- Ruminations (thinking about topics with no answers)

the effect of weakening the vicious OCD cycle.

For up to a third of people with OCD, medications can be effective in relieving symptoms in the short term. However, to enjoy the gains in the long term, the person must stay

stand his illness, and now, they are much more supportive of him.

"Stigma is still such a major issue for people with a mental illness," he says. "The support group put me in touch with other people who understood and shared the same concerns that I had, and gave me a lot more confidence in myself."

Famous people who have or are thought to have OCD:

Donny Osmond
Howie Mandell
Marc Summers
Billy Bob Thornton
Florence Nightingale
Charles Darwin

Howard Hughes
Roseanne Barr
Howard Stern
Hans Christian Andersen
Woody Allen

on the medication. SSRIs (selective serotonin reuptake inhibitors), a family of antidepressants, have been found to be the most effective medication for the disorder and can be particularly effective for treating symptoms of depression that co-exist with OCD. However, other kinds of medicine may also work.

Finding the right medication can be frustrating however, as Dutta found out. "For one thing, dealing with the side-effects can be extremely traumatic. I would have muscle or facial twitching, extreme headaches, slurred speech, and would often feel sedated. It ends up that the treatment is controlling you, instead of the disease." However, once he found the right medication and tried other sorts of treatments, he began to feel much better and was able to keep the illness under control.

Unfortunately, obsessive-compulsive disorder tends to be underdiagnosed and undertreated. This is partly because many people with OCD are ashamed and secretive about their symptoms. They realize that the thoughts are illogical and therefore feel embarrassed to reveal them to their physician. Moreover, many health care practitioners are not well-informed about the condition. This is where community support groups and support from friends and family are also key factors in helping ease the already-high anxiety and accompanying stigma associated with this disabling illness. Loved ones can also act as advocates in the service system for a person often too ill to be in a position to stand up for their needs.

For Dutta, embracing both sides of treatment — cognitive restructuring techniques and medication — and becoming active in a support group — first as a participant and later, as facilitator — have enabled him to learn to manage his life much better. Moreover, the support group helped his family and friends to under-

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Post-traumatic Stress Disorder

Human beings are incredibly resilient. However, some situations are so shocking and shattering that they can affect our minds, bodies and perceptions severely for a long time afterwards. When a traumatic event continues to influence our behaviour and have a negative impact on our lives for a long time after it occurs, this can be a sign of post-traumatic stress disorder, notes the CMHA.

Post-traumatic stress disorder, or PTSD, is one of several conditions known collectively as anxiety disorders: the most common type of mental disorder, affecting 12% of the population in any given year. We all feel anxious in certain situations, and anxiety can be helpful in motivating us and in improving our ability to deal with a crisis situation. For some people, however, anxiety can become so persistent and relentless that it interferes with their day-to-day functioning.

As its name suggests, post-traumatic stress disorder affects people who have gone through a traumatic event in their lives such as a disastrous earthquake, war, rape, a car or plane accident, or physical violence. Sometimes, seeing another person harmed or killed, or learning that a close friend or family member is in serious danger can cause the disorder. Richard, an ambulance emergency worker in BC, developed PTSD from the highly stressful work that he does. It was triggered when he was called to respond to a sudden death, which turned out to be a fireman that he knew.

Despite the seeming rarity of some of these events, PTSD will affect approximately 1 in 12

people at some point in their lives. Twice as many women as men develop the disorder, although the reasons for this are unclear.

A person who has PTSD is constantly reminded of their responses of horror, fear and helplessness to the traumatic event. These states continue to manifest themselves in the person in several ways.



For instance, the person may re-experience the event through recurrent nightmares, flashbacks and intrusive memories. This is the most characteristic symptom of PTSD, and often its most distressing. The anniversary of the triggering event, or situations which remind a person of it, can also cause extreme discomfort and anxiety. Increased arousal and anxiety in general is another common feature, where a person may become hypervigilant, sleeping less and being constantly on the alert. Some people with PTSD have difficulty concentrating and finishing tasks and can also become more aggressive.

Perhaps to protect a person from the emotional and physical intensity of some of the above symptoms, avoidance and emotional numbing are also characteristic of the disorder. The person may feel guilty, avoid talking or thinking about the trauma, withdraw from family and friends, and lose interest in activities they previously enjoyed. They may also begin to have difficulty feeling emotions, especially those associated with intimacy. In rare cases, a person may enter dissociative states, or a detached feeling of watching yourself go through something from the outside, particularly when believing they are re-living the episode.

PTSD can develop in both children and adults. While the symptoms usually begin about three months after the traumatic event, on occasion they may surface years later. Moreover, it is common for depression, drug or alcohol dependence,

Types of Trauma

- **Natural disaster**, such as:
 - hurricane
 - earthquake
- **Crime**
 - rape or physical assault
 - burglary, mugging or hold-up
- **War**
 - military combat
 - war crimes
 - torture
 - being in a constant state of alert
- **Major accident**
 - workplace
 - automobile
 - airplane
- Witnessing any of the above

Warning Signs of PTSD

While it is fairly common for some people to have an acute stress response to a traumatic event, only a small but significant proportion of people will go on to develop post-traumatic stress disorder. However, individuals who feel they are unable to regain control of their lives, or who experience the following symptoms for more than a month should consider seeking professional help.

Symptoms to watch out for include:

- Recurring thoughts or nightmares about the event
- Changes in sleep patterns or appetite
- Anxiety and fear, especially when exposed to events or situations reminiscent of the trauma
- Feeling "on edge," being easily startled or becoming overly alert
- Spontaneous crying, feelings of despair and hopelessness or other symptoms of depression
- Memory problems including difficulty in remembering aspects of the trauma
- Feeling scattered and unable to focus on work or daily activities
- Difficulty making decisions
- Irritability or agitation
- Anger or resentment
- Guilt
- Emotional numbness or withdrawal
- Sudden overprotectiveness and fear for the safety of loved ones
- Avoidance of activities, places or even people that remind you of the event

or another anxiety disorder to co-occur with PTSD.

As more information on post-traumatic stress disorder has come to light in the last few years, prevention strategies have begun to be implemented. For instance, when a major traumatic event like a school shooting occurs, survivors are often given counselling afterwards so that they can deal with the event.

For those people who do develop symptoms beyond just an initial acute stress response, there are treatments that exist to help people recover from the impact of traumatic stress.

Group-based or one-on-one cognitive behavioural strategies are particularly successful because they address specific fears, thoughts and emotions lingering from the trauma. With time, treatments like these can help a person come to grips with the trauma, find closure and move beyond the event towards healing. Eventually, most people are able to reach a point where they feel comfortable in their own skin again and are able to remember without reliving.

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Panic Disorder

Panic attacks are terrifying episodes during which the person is convinced that they are about to die or collapse. They may be suddenly overwhelmed by physical and emotional sensations that feel like they signal imminent death such as heart palpitations, nausea, dizziness, faintness, chest pain, choking and sweating. Such attacks are actually a common occurrence; about a third of adults will experience a full panic attack in any given year. However, when panic attacks occur in a person so regularly and to such an extent that they begin to seriously interfere with daily life, a person may have panic disorder.

Panic disorder is one of several types of anxiety disorders that collectively affect 12 % of Canadians in any given year. Anxiety disorders are the most common of all mental health problems, according to CMHA. They affect a person's behaviour, thoughts, emotions and physical health. Fortunately, they are diagnosable and treatable.

Panic disorder, in particular, affects about 2.5 % of Canadians — almost three times as

many Canadians as have schizophrenia. On average, it appears in a person's mid-20s, and like most other anxiety disorders, is treated more commonly in women than in men.

A person with panic disorder does not simply experience panic attacks in a stressful or anxiety-provoking situation. He or she may experience panic at any time, often when there is no real danger. Also, panic attacks are not to be confused with the panic-like feelings associated with medical conditions like heart murmurs, or those that occur as a consequence of drug or alcohol use, or caffeine consumption.

Heather began having panic attacks when she was 19, and panic disorder continues to



Benzodiazepine Addiction

Benzodiazepines — minor tranquilizers such as Valium or Ativan — are often prescribed to treat panic disorder and to help relieve anxiety, stress or sleeping problems. These pills may be helpful when used as part of a larger coping strategy. However, their use must be limited and carefully supervised since prolonged use of these drugs can result in dependency and severe withdrawal symptoms.

Signs of dependency:

- Daily doses (even small) for a month or more
- Increasing your dose over time
- Feeling the effects are wearing off (as a result, you may find yourself taking more of the drug or trying different brands)
- Monitoring your supply of pills and making sure you never run out
- Carrying your pills with you
- Taking "extra pills" when situations are stressful
- Unsuccessful attempts to quit or cut down
- Inability to cope without the drug
- Cravings for the drug
- Extreme discomfort if a pill is missed

If you think you might be dependent, don't stop your medication suddenly. Instead, ask a doctor or addictions counsellor about a withdrawal plan as well as other alternatives to help you address the underlying anxiety. Friends, family, support groups and spiritual communities can help provide support and encouragement through this process.



be a part of her life today. "When I'm having a panic attack, there is a sense of unreality combined with sheer terror," she says. "It's almost indescribable. I get this horrible feeling in the pit of my stomach, and I feel like throwing up. The terror is unexplainable."

A subcategory of panic disorder is panic disorder with agoraphobia. Agoraphobia is a specific kind of phobia where the person is afraid of being in places or situations which would be difficult to escape from, or in which it would be difficult to find help, should they suffer a panic attack.

People with agoraphobia often go to great lengths to avoid such situations. For example, they may avoid taking public transportation or stay away from shopping malls and other crowded places. Sometimes, people develop a fear of being alone. Conditions like these can cause a person with this condition to shut themselves in their homes, sometimes for years at a time. For Heather, she began to have anticipatory anxiety, and started avoiding all the situations where she thought she might have a panic attack.

Although the causes of panic disorder — in all its variations — are still being researched, studies have shown that the occurrence or anticipation of stressful life events, anxiety in childhood, over-protective or anxious parents, perfectionistic tendencies and substance abuse are common among people with panic disorder.

A variety of approaches to treatment for

the disorder have been found to be effective. Some people take medications like antidepressants or anti-anxiety drugs to decrease symptom severity.

Cognitive-behavioural therapy also shows tremendous benefits, in combination with medication or not, because it targets the source of future attacks: the thoughts. A combination of cognitive restructuring (that challenges 'catastrophic thinking') and behavioural strategies (that gradually expose the person to the anxiety-arousing situations) are the most successful techniques. They can also involve exploring what exactly triggers the person's panic and how to deal with it when it occurs.

Heather believes that public education about panic disorder is essential as well. "Panic disorder is a disability that's as extreme and disabling as any physical disability," she says. "When I first started having panic attacks when I was young, there was no information about it out there. I thought I was not normal. It's really good to know now that I'm not the only one out there who's going through this."

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Schizophrenia

When schizophrenia hits the news, it is usually linked to bizarre and frightening crimes that lead the public to believe that most people with this illness are violent and dangerous. But these highly publicized cases represent only a small fraction of people living with schizophrenia, according to the BC Schizophrenia Society (BCSS).

Although it affects around 40,000 people in British Columbia (about 1 in 100 Canadians), schizophrenia is one of the most widely misunderstood of all mental illnesses, reports the BCSS.

A 2001 study by Calgary researchers for the World Psychiatric Association's campaign against stigma found that nearly half of Albertans surveyed still confuse schizophrenia with multiple personality disorder, a less common and entirely different psychiatric disorder.

Most people in BC do not recognize the signs of schizophrenia, nor do they understand that it is a serious mental illness caused by a chemical disturbance of the brain's functioning. As a result, people with untreated schizophrenia are sometimes mistaken for alcoholics or drug addicts because onlookers have no other explanation for their unusual behaviour which may include acting paranoid or talking to someone who isn't there.

The confusion arises from a lack of public education and from gaps in medical knowledge about schizophrenia.

Researchers do not fully understand what causes the illness, but the consensus is that schizophrenia involves changes in the chemistry and structure of the brain, as well as genetic factors, writes Dr. Nancy Andreasen.

Facts and Myths about Schizophrenia

- schizophrenia is not caused by bad parenting, childhood trauma, poverty, street drugs or alcohol
- schizophrenia is not contagious
- although people with schizophrenia sometimes hear "voices" in their heads, this illness is very different from split or multiple personality disorder (now called dissociative disorder)
- schizophrenia is not a person's fault; it is a chemical brain disorder caused by a combination of biological and genetic factors, and often triggered by environmental stressors
- people with this illness are at risk of harming themselves: since about 40% of people with schizophrenia attempt suicide and 10-20% will actually commit suicide, all talk of suicide should be taken seriously

author of *The Broken Brain: The Biological Revolution in Psychiatry*.

Each of the billions of nerve cells in the brain has branches that transmit and receive messages from other nerve cells. These branches release chemicals called neurotransmitters which carry messages between cells. Researchers believe that schizophrenia interferes with this chemical communications system. Incoming perceptions get routed along



the wrong path, get jammed or end up at the wrong destination, much like a short-circuit in a telephone switchboard.

As a result, people with schizophrenia often have difficulty thinking and talking in a consistently clear and organized manner. They may feel anxious and disoriented, and may lose the ability to relax, sleep and experience pleasure. Although schizophrenia affects each person differently, some people with this illness hear voices that comment on their behaviour, insult them or give commands. Others experience a blurred sense of reality involving hallucinations that may be enjoyable or extremely frightening.

Maurizio Baldini, a 44-year-old lawyer re-

LANGUAGE FACT

Schiz- or schizo- in Latin means "split." This may be one of the reasons the general public and the media continue to incorrectly associate schizophrenia with having "split" or multiple personalities (now known as dissociative disorder, entirely unrelated to schizophrenia except that both are mental illnesses).

In fact, the *schiz-* in schizophrenia does mean split but it refers to the **split from reality** someone going through a psychotic episode lives with; NOT a splitting off of him or herself.

covering from schizophrenia, says he heard demonic voices during an acute period of his illness. "These grotesque distortions tormented me day and night until I could no longer distinguish between reality and nightmares," he says.

At times, his unusual thoughts jeopardized his personal safety. "In hindsight, one of my most dangerous delusions was probably the belief that I could fly, because if I had found a tall building, I might have easily climbed to the top and tried to jump off to test it out."

Baldini's symptoms came on suddenly at the age of 22. However, acute schizophrenia often appears after a gradual build-up of symptoms that sometimes begins in childhood. According to the BCSS, schizophrenia affects both men and women and usually strikes between the ages of 15 and 30.

Although there is no known cure for the illness, schizophrenia can be treated with a combination of medication and supportive therapies. Key to recovery is recognizing the signs and symptoms of the illness and getting help immediately, particularly at the first episode of psychosis. This can help prevent delusions from "hardening" and reduce the impact of the illness on the person's vocational and social goals. Another important aspect of a modern treatment plan is psycho-education which provides the person with the information and skills needed to adequately understand and deal with the illness in the context of their daily lives. The newer medications also represent a giant step forward since they enable people to think and function at a much higher level than older drugs allowed.

About one-third of people with schizophrenia have a severe episode of the illness only once during their lifetimes. Another third have long periods of stability and are able to live independently in the community with occasional help. The last third require more support and longer periods in the hospital to deal with their on-going symptoms.

Although Baldini has experienced several acute episodes of schizophrenia, he leads a full life and is an active member of his community. In the 22 years since the onset of his illness, he has worked as a lawyer, a legal research assistant for the BC government and a mental health advocate.

He says the support of other people has been a major part of his recovery. "The other person acts as a sounding board and gives feedback on a day to day basis and helps one grow and gain insight," Baldini says. "I feel that successful relationships are a key factor in overcoming serious illnesses like schizophrenia."

Symptoms of Schizophrenia

- changes in appetite and weight
- extreme lethargy and lack of motivation to complete tasks
- an emotional "flatness" and difficulty experiencing pleasure
- a strong desire for solitude
- unusual tearfulness and deep sadness
- scattered attention and difficulties with concentration
- frequent thoughts of death or suicide
- difficulty making decisions, even small ones
- a sense of failure and a loss of self-esteem
- difficulty maintaining personal hygiene
- a sense of being watched or followed
- hallucinations (e.g. hearing "voices" in one's head) or delusions

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Eating Disorders & Body Image

Eating disorders and body image dissatisfaction were once the domain of an obscure branch of psychiatry. But in recent decades, our culture has bombarded people with images of an ideal physique that is increasingly out of reach for the average person. According to eating disorders expert David Garner, body image dissatisfaction is increasing at a faster rate than ever as more and more people compare themselves unfavourably to this ideal. The question today is no longer "Who has a poor body image?" but "Who doesn't?"

A recent poll conducted by People magazine found that only nine per cent of women were complete happy with their bodies and 93% had tried to lose weight. In Canada, the situation is roughly the same, with almost half of women saying they consider themselves overweight.

Lisa Berzins, a psychologist and eating-disorders expert who visits schools wearing a fat suit to hide her slender figure, has found that fear of being fat is so overwhelming that young girls have indicated in surveys that they are more afraid of becoming fat than they are of cancer, nuclear war, or losing their parents.

The situation is even more alarming in the schools. A survey by BC's McCreary Centre Society of almost 26,000 high school students revealed that about half of both male and female students were unsatisfied with their weight. Even among students whose actual weight and height were average and healthy, 80% of females wanted to weigh even less and 60% of boys wanted to weigh more. Even 30% of pre-teen girls 13 and younger reported they had dieted in the past week.

In a study in Ontario of 2483 female students significant symptoms of eating disorders

Some Warning Signs of an Eating Disorder

- I often gain and/or lose large amounts of weight
- I am always thinking about food, dieting and my weight
- I often avoid food even when I am hungry
- I feel guilty and ashamed of my eating
- I often feel out of control when I eat
- I feel better when I don't eat
- I often gorge myself on food
- I feel fat even though others tell me I'm not
- I feel worthless when I think of my body and my weight
- I will never be happy unless I reach my ideal weight
- I don't like eating with other people
- I rarely/never get my menstrual period
- I often "get rid" of food by using laxatives, exercising vigorously or making myself vomit

Source: Eating Disorder Resource Centre of BC

and bingeing and purging, or both, were reported by 27% of girls aged 12-18 years. Dieting was the most prevalent weight-loss behaviour, also common was other unhealthy weight-loss behaviours such as self-induced vomiting.

Body image is the picture an individual has of his or her body and what she or he thinks it looks like to others. Researchers believe that concern over body image is really a mask for how a person feels about themselves: their self-esteem. In North America, body image has come to mean even more. For example, thinness not only represents attractiveness, it has also come to symbolize success, power, self-control and higher socioeconomic status, according to Dr. Liz Dittrich, who researches body image issues. Maria Hutchinson (1985) found in her research report *Transforming Body Image*, 80-90% of women dislike the size and shape of

Elements of a Successful Treatment Plan for Eating Disorders

- individual counseling to address core issues (e.g. low self-esteem, need for control) and to encourage the person to express their feelings, especially those of anger and sadness
- antidepressants for reducing depression, anxiety and impulsive behaviour, especially for people with bulimia
- dental work to repair damage caused by malnutrition or stomach acids from frequent vomiting
- nutrition counseling to debunk food myths and plan healthy meals
- support groups to break down isolation and alienation
- family counseling to provide support and help replace old patterns with healthier new ones
- hospitalization to prevent death, suicide and medical crisis in people with severe eating disorders

What would you do to be thin?

- percentage of women who have tried to lose weight: 93 %
- percentage of women who have tried over-the-counter or prescription diet pills: 51 %
- percentage of women who would be willing to try a diet even if it posed at least a slight health risk: 34 %
- percentage of women who had or would consider having cosmetic surgery to be thin: 34 %
- percentage of women who admit they smoke cigarettes to lose weight: 12 %
- percentage of women who have turned down a social invitation because of insecurity about their physical appearance: 28 %

Source: People Magazine poll of 1000 women

their bodies." According to Awareness and Networking around Disordered Eating (ANAD) this information demonstrates that the difference between poor body image, unhealthy dieting, and an eating disorder is usually a matter of degree.

In BC, eating disorders affect men and women of all ages, shapes, sizes and socio-economic backgrounds.

Women are more likely to have eating disorders than men. However, Marilyn Lawrence, a psychoanalyst at the Tavistock Clinic in the UK, has documented that men are often forgotten because their eating disorder goes undiagnosed, yet about one in ten men is affected with bulimia. Bulimia and other eating disorders are increasingly common in males, particularly among athletes and body builders concerned with perfecting their appearance.

Dr. Laird Birmingham (2003), the Director of the Provincial Eating Disorder Program, states that in BC, at any given point in time, anorexia nervosa is estimated to represent 1 % of the female population (15,000) and 0.1 % of the male population (1,500). 3 % of the female population (45,000) and 0.3 % of the male population (4,500) suffer from bulimia nervosa.

People who develop bulimia nervosa may lose weight, remain the same weight or even gain weight. They have frequent periods of uncontrolled binge eating followed by some type of purging to rid the body of unwanted calories. After a binge, people with bulimia may force themselves to vomit, purge with laxatives, use diuretics, go on a fast or exercise excessively, according to ANAD.

People with anorexia nervosa have an extremely distorted body image. They see themselves as fat and overweight even

though their weight may be normal or dangerously low for their age, height and body type. People with anorexia may exercise for hours a day or go for days without eating in order to be thin. Many people with anorexia resist help from others because they fear they will be forced to eat and gain weight. But early diagnosis and treatment can be crucial to survival since anorexia can cause severe malnutrition, dangerously low pulse and blood pressure and even death from starvation. Of those patients diagnosed with anorexia nervosa, 50 % have chronic illness compared to 30 % with bulimia nervosa who struggle with chronic illness. The annual estimated BC direct and indirect costs for eating disorders is \$400 million.

Sadly, eating disorders have the highest mortality rate of all mental illnesses and annual death rate associated with anorexia is more than 12 times higher than the annual death rate due to all other causes combined for females between 15 and 24 years old.

Kathleen, 43, developed bulimia at age 25 and, for 16 years, continued to make herself vomit after eating. "I was bingeing and purging at least six days a week, usually several times a day." Kathleen says her body image changed dramatically when other people started complimenting her over her weight loss.

Kathleen says her sense of being in charge of the binge/purge cycle changed as her illness progressed. "It got control of me, I didn't have control of it," she says. "What I know is that there's no end to it. When you're bingeing and purging you can just keep eating all day."

"For the longest time I felt exhilarated by my bulimia," she says. "I lost that 15 pounds that made me average... it made me feel powerful and I guess part of that was the control."

Kathleen says the never-ending cycle of bulimia resulted in "a real sense of being lost." Other people associate bulimia with intense feelings of shame, guilt and self-loathing, says ANAD. Some people with this disorder even contemplate suicide.

These feelings may seem extreme, but evidence suggests that they may be amplified versions of the dislike and sense of powerlessness many people feel in relation to their bodies. Attempts to diet may increase this sense of failure and frustration since 95 to 98 % of all dieters regain their weight, according to Dr. Dittrich. A study in 1999 found that dieting may lead to a drop in brain serotonin levels, which may in turn make dieters more vulnerable to bingeing and purging habits.

Fortunately, anorexia and bulimia are treat-

able disorders, particularly if they are identified early. People with either mild or severe eating disorders can benefit from supportive therapies that focus on changing their feelings about their body, improving self-esteem and providing tools for establishing normal eating habits and preventing relapse. Treatments may also include medications for depression and group therapy for the person and his or her family.

For Kathleen, deciding that thinness was less important than her well-being was an essential part of her recovery. She says she now takes pride not in weight loss from self-induced vomiting but in her two and a half years of freedom from bulimia. "I'm 40 pounds heavier, and I'm living with it," she says.

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Facts on Eating Disorders

Prevalence:

- approximately 1% of young women have anorexia
- approximately 4% of young women have bulimia
- 10% of people with eating disorders are male
- for both sexes, the rates are even higher among athletes participating in sports emphasizing a lean body type (e.g. dancing, gymnastics, skating, swimming, diving, wrestling, gymnastics and figure skating) and individuals under strong pressure to achieve (e.g. medical students, models and competitive athletes).
- without treatment, up to 20% of people with serious eating disorders die. With treatment, the number falls to 2-3%.

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Alzheimer's Disease and Other Forms of Dementia

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Most people approaching retirement look forward to exploring new pursuits and basking in memories of their long and eventful lives. But for thousands of Canadians, Alzheimer's disease replaces the richness of the golden years with a sense of loss and confusion as memories of the past and present gradually fade.

Although memory loss is common among the elderly, Alzheimer's disease is *not* part of normal aging, according to the Alzheimer Society of BC. It is a progressive neurological disease that affects the brain and many of its functions including language, intellect and spatial orientation.

"In fact, most older people make it through to a ripe old age with no sign of Alzheimer's," says Kern Windwraith of the Alzheimer Society of BC.

The illness develops so gradually that it is hard to notice at first. The symptoms resemble ordinary memory lapses. As the lapses become more frequent, people with Alzheimer's lose the ability to learn and remember anything new. At first they forget things from week to week, then from day to day, and gradually, from hour to hour and even minute to minute.

Eventually people with Alzheimer's disease can no longer remember the names of family and friends or find their way around in places that are not completely familiar. They may avoid social contacts because they can't follow the drift of a conversation. At this stage, many people can still live well using simple routines in a familiar environment. But they may experience a sense of powerlessness and frustration that can lead to emotional turmoil.

For example, when they are upset by an otherwise trivial event, a person with Alzheimer's may break into tears, strike out in anger or try to run away. They sometimes become suspicious and develop delusions, talking to imaginary persons or accusing fam-



tors.

"There is a feeling of horror when you are losing your independence and realize you need to depend on others for your most basic needs," Windwraith says. The emotional turmoil affects people at different stages, she adds. "For a spouse, Alzheimer's means losing your life partner right before your eyes."

In later stages of the disease, people with this illness do not recognize the faces of their closest relatives. They may have trouble dressing or feeding themselves because they are unable to hold a thought long enough to form a goal. Often, people with Alzheimer's pace in an agitated way or wander aimlessly.

Rates of Alzheimer's Disease and Related Dementia:

- in Canada, 364,000 people 65 and older have dementia, with Alzheimer's disease representing about two-thirds of all dementia cases
- by 2031, this number is expected to increase to 778,000
- in BC, over 50,000 people have dementia with that number expected to nearly double by 2031.
- at least one in 12 people aged 65 or older have Alzheimer's disease or a related dementia
- the rates of Alzheimer's increase with age:
 - 1% of people aged 65 to 74
 - 7% of people aged 75 to 84
 - 26% of people aged 85 and older

Source: Canadian Study of Health and Aging Working Group

Life skills are lost in more or less the reverse order they are learned in childhood, starting with handling money, choosing clothes, bathing and using the toilet, feeding one's self, talking, walking and even sitting up. As the disease progresses, they lose control of their bowels and bladders and have increasing difficulty sleeping.

Once the brain loses the capacity to regulate elementary body functions, people with Alzheimer's die of malnutrition, dehydration, infection or heart failure. The interval between the earliest symptoms and death is two to twenty years, with an average of seven to ten.

Alzheimer's disease is the most common form of a group of degenerative brain diseases known as dementia. Other forms include Pick's disease, Creutzfeldt Jakob disease, Lewy body dementia, vascular dementia and primary progressive aphasia, among others. Although these illnesses affect other parts of the brain, most of the symptoms resemble those of Alzheimer's disease, says Windwraith of the Alzheimer Society.

Alzheimer's disease and related dementia cannot be cured, reversed or stopped in their progression. Today's treatments, which may include medications, are designed to reduce the symptoms and help both the patient and the family live through the course of the illness with greater dignity and less discomfort. "Alzheimer's not only affects the person with the disease, it affects the whole family," Windwraith explains.

The CMHA encourages individuals with Alzheimer's and their families to seek help from support groups, counsellors and community services which are available through-

out BC. Many families qualify for government subsidies that help cover the expense of caring for a relative with Alzheimer's. Some organizations including the Alzheimer Society of BC offer support services for individuals with Alzheimer's at no charge, Windwraith adds.

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Help for Individuals with Dementia and their Families:

The Alzheimer Society offers support services and provides information on treatments and care strategies:

- **support groups**, telephone or peer counselors can provide emotional support
- **relief programs** provide short-term respite for caregivers, day programs; overnight or vacation programs can provide a needed break
- **homecare workers** provide personal care to individuals at home, assisting with eating, dressing and bathing as well as light household tasks
- **housekeeping services** can help with cleaning, shopping, laundry and meal preparation
- **skilled nursing services** provide trained professionals in the home
- **Meals on Wheels** offers home-delivered meals for well-balanced lunches and dinners

Source: Alzheimer Society of Canada

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Concurrent Disorders: Addictions and Mental Disorders

In BC, people with mental illness usually have access to treatment if they are able and willing to seek help. The waiting lists are longer for people with substance use problems. However, self-help groups can provide support in the meantime. But what about people who have both?

People with concurrent disorders — the combination of a mental illness and substance use disorder (sometimes called 'dual diagnosis') — often fall through the cracks in the province's health care system, reports the Canadian Mental Health Association (CMHA) and the Kaiser Foundation.

Mental health services may refuse treatment to a person with an active drug or alcohol addiction, while addiction professionals may believe that a person cannot recover from problem substance use until the mental disorder is treated. As a result, people with concurrent disorders are sometimes bounced back and forth between both mental health and addiction services or they may be refused treatment by each of them.

Although Greater Vancouver has a small concurrent disorders program, it is not equipped to serve the growing number of people with these illnesses in Vancouver, let alone in the rest of the province.

Concurrent disorders is much more widespread than many people realize. For example, a CMHA survey conducted in BC found that 55% of mental health service users interviewed had substance use issues that accompanied their first episode of mental illness.

The relationship is complex. Mental health problems can act as risk factors for substance use problems. For example, depressive symptoms could lead someone to self-medicate with alcohol for temporary relief from symptoms of depression or the side-effects of the medications they must take to manage their depression. Or, it could be that someone with an anxiety disorder or depression has trouble sleeping and is given tranquilizers which can then be misused.

Substance misuse may induce, worsen, or diminish psychiatric symptoms, complicating the diagnostic process. For example, psychiatric symptoms may be covered up or masked by drug or alcohol use. Alternatively, alcohol or drug use or withdrawal from drugs or alcohol can mimic or give the appearance of some psychiatric illnesses. Misuse can also act as risk factors for mental illness. For example, struggling with an addiction and its consequences affects your mental health: your moods, behaviours, perceptions, coping strategies and social networks.

There are also common risk factors that place people at risk for either substance use or mental health problems, or both: poverty or unstable in-

come, difficulties at school, unemployment or problems at work, isolation, lack of decent housing, family problems, family histories, past trauma or abuse, discrimination, and even biological or genetic factors. And like other people, a person with concurrent disorders may use drugs and alcohol to cope with boredom, depression or anxiety and to increase opportunities for social contact.

The drug of choice is usually alcohol, followed by marijuana and cocaine. People with mental disorders may also become addicted to prescription medications such as tranquilizers and sleep medicines.

Allan, 32, says he sometimes binges on alcohol and marijuana to cope with symptoms of post-traumatic stress disorder which he developed as a result of childhood sexual abuse.

"I definitely abuse alcohol occasionally ... they [mental illness and substance abuse] definitely go hand in hand just because you want to get out of yourself. You hate being in your own skin because of the feelings," he says.

Do Substance Use and Mental Illness Go Hand in Hand?

Studies estimate that:

- at least 50% of people with mental illness abuse illegal drugs or alcohol, compared to 15% of the general population
- 12-18% of people with anorexia and 30-70% of people with bulimia also have substance use disorders
- 47% of people with schizophrenia exhibit problem drug use: cocaine may be particularly problematic
- 56% of people with bipolar disorder (manic depression) have a substance use disorder
- more than a third of people with an anxiety disorder also have a substance use disorder

Some people may find they are more easily accepted by groups whose activities are based on drug use. Others may believe that an identity based on drug addiction is more acceptable than one based on mental illness.

The complexity of concurrent disorders can make the combination of conditions difficult to identify. For example, a person with a substance use problem, their friend or a family member may think the beginning symptoms of mental illness are "just the drugs," that is, a reaction that will go away when the drug use stops.

Some families may neglect to mention their relative's problem drug or alcohol use to health care professionals because they believe it is a symptom that will clear up once the person receives treatment for the mental illness. Others

view drinking or drug use as the best "leisure" activities a person with serious mental illness can expect.

However, substance abuse is just as devastating for people with mental illness as it is for other people, if not more so, according to the Dual Diagnosis Program of Greater Vancouver:

People with dual diagnosis can get caught up in a vicious cycle that involves multiple living problems resulting from poverty, lack of support systems, isolation, physical illness, housing difficulties, disrupted family functioning and interpersonal relationships, and negative experiences with previous treatment.

Substance use complicates almost every aspect of care for people with mental illness, adds Kathleen Sciacca, a New York-based expert on concurrent disorders. Because people with concurrent disorders face additional barriers to adequate treatment and housing, they are more likely to experience relapses and frequent hospitalizations than people with mental illness alone. Other researchers say the toxic mix of prescription medication combined with alcohol and/or illicit drugs can cause severe drug reactions and may even trigger psychiatric symptoms. Additionally, the symptoms of a coexisting psychiatric disorder may be interpreted as poor or incomplete "recovery" from alcohol or other drug addiction.

Despite this gloomy picture, people with concurrent disorders can recover from an addiction if they receive appropriate treatments tailored to their needs. According to Sciacca, the key is to avoid the therapeutic approach of traditional addiction programs such as heavy confrontation and intense emotional jolting. This can cause levels of stress that work against recovery for people with mental disorders.

Sciacca recommends a non-confrontational approach that allows people with concurrent disorders to recover at their own pace through education and discussion in a group setting. She stresses the importance of nonjudgmental acceptance of all symptoms and experiences related to both mental illness and substance abuse. Although abstinence from drugs and/or alcohol is the goal, it should not be required for entering treatment, she adds.

"Clinicians have to convey to the [participants] that they realize how hard it is to stop. They have to give [them] credit for any accomplishment. That's where the focus has to be — on any inch of progress," Sciacca writes in *New Directions For Mental Health Services*.

People participating in Vancouver's Dual Diagnosis Program must be sober while attending orientation sessions, but a commitment to abstinence is required only for people who wish to move on to the program's treatment groups.

The orientation groups provide information about the program and education on the rela-

tionship between substance abuse and mental illness. The group treatment programs which last up to six months cover topics ranging from relapse prevention and anger management to strategies for developing a recovery support system, accessing community services and making positive lifestyle changes. The centre also offers a maintenance program for people who wish to work on ongoing life issues and concerns.

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Treatment in BC

- The Dual Diagnosis Program of Greater Vancouver is an out-patient service offering limited access to one-on-one counselling, an addictions specialist, a psychiatrist, and a resource centre. For information call and leave a message at (604) 255-9843
- Vancouver Community Mental Health Services also offers a concurrent disorders program specifically for youth 12 to 24 in age. To find out more, contact (604) 251-2264
- There are two residential treatment programs available in the lower mainland including Berman House in Vancouver (604-254-6065) and the Concurrent Disorders Programs in Port Coquitlam at (604-524-7089)
- Some addiction treatment centres accept people with concurrent disorders, but these services are not geared towards the specific needs of people living with mental illness.

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Fetal Alcohol Spectrum Disorder

Fetal alcohol spectrum disorder (FASD) refers to a range of birth defects caused by drinking alcohol during pregnancy. Fetal Alcohol Syndrome (FAS) is the term used to refer to a person who has slowed growth, certain facial characteristics, and also brain damage; Partial Fetal Alcohol Syndrome (PFAS) is used to refer to people who have some but not all of these abnormalities; Alcohol-Related Neurodevelopmental Disorder (ARND) refers to the variable range of central nervous system dysfunctions that are associated with alcohol consumption during pregnancy. Although the term Fetal Alcohol Effects (FAE) is being phased out, it still appears in the literature, usually referring to PFAS.

The effects of alcohol on a fetus are more harmful than those of any other drug (including cocaine). When a pregnant woman drinks alcohol, it reaches the placenta in a few moments and passes through the growing fetus. While the mother's body can break down a drink in about three hours, alcohol stays in the fetus for much longer.

FASD is a significant public health concern in Canada. It is estimated that in North America, between 1 and 3 of every 1,000 live births are affected by FAS. The rates for PFAS and ARND are likely to be much higher. This range of disorders have been identified as one of the leading preventable birth defects in Canada.

The most significant problems associated with FASD are due to brain abnormalities, and the behavioural problems that arise. Children with FAS tend to have difficulties with things like developing a regular sleeping schedule, or toilet training, and are prone to impulsivity and hyperactivity. Teenagers with FASD often have low self-esteem because of the social and learning differences between themselves and their peers. They may do unsafe things in order to be accepted, such as taking a dangerous dare or engaging in sexual activity to gain acceptance. They frequently exhibit low impulse control and poor judgement. Discipline can be a problem, as people with FASD often have difficulties understanding consequences.

Both as adolescents and adults, those affected by FASD may have trouble living up to society's demands. School and work can be a struggle as they have difficulty paying attention, have poor organizational skills, and have trouble completing tasks. Personal relationships can be difficult, as people with FASD may have trouble both with setting their own personal boundaries, and with observing other people's boundaries.

Since the symptoms of FASD are permanent, the problems arising from the disorder are not limited to dealing with affected children. While this is a huge challenge from a parenting perspective, adults with FASD also have significant difficulties. Often they are unable to live inde-

pendently, and require supported housing and employment programs. People affected with FASD also face unique challenges when they themselves attempt to parent.

In addition to these difficulties, people with FASD are commonly diagnosed with co-occurring disorders. Frequent concurrent disorders include conduct disorder, depression, obsessive compulsive disorder, oppositional defiant disorder, and attachment disorder. Depression is the most commonly occurring secondary disorder, affecting 40% of people with FASD. People with FASD also experience a high rate of problems with substance use. These co-occurring problems can be reinforced by social isolation, anger management problems, and difficulties with personal relationships, all of which are associated with FASD.

Many people affected by FASD (research suggests about 60% of sufferers) have been in trouble with the law. Several symptoms associated with FASD are associated with delinquency and crime, for instance poor impulse control, hyperactivity, poor frustration and anger control, inappropriate sexual behaviour, and trouble understanding consequences. Since people with FASD are overrepresented in the criminal justice system, it has been recommended that Correctional Services Canada consider designing and evaluating a special institutional program for this population.

FASD is a preventable disorder. Mothers who drink or consume other drugs while pregnant are often negatively portrayed, and policies and approaches to the problem have often taken a punitive attitude. Women may be sent to jail, where they are unlikely to find treatment for their substance use problems. Often the children are removed from the care of their birth mothers.

Signs of FASD

In order for a doctor to make a diagnosis of FAS, three criteria must be present:

1. Characteristic facial features, which include: a flattened midface; thin upper lip; indistinct or absent groove between upper lip and nose; and short eye slits.
2. Slowed growth, prenatal and/or postnatal.
3. Central Nervous System neurodevelopmental disabilities, such as: impaired fine motor skills, learning disabilities, behaviour disorders or a mental handicap.

For a diagnosis of PFAS, two of the three above criteria must be present, and must include some facial features and brain differences.

To receive a diagnosis of ARND only one of the three criteria must be present, and must be a brain difference. All of these symptoms are permanent, and cannot be outgrown.

Source: FAS/E Support Network of BC

Research has shown that such measures may not be the most effective; however, there are some successful programs designed to reach women at high risk for giving birth to children damaged by substance use.

In the most effective programs, the woman's partner, family, friends, doctor, social worker, alcohol and drug counsellor, public health nurse and others with whom she comes in contact, are involved in helping her decide to change and to find the support she needs. This approach is based on the consistent finding that unsupportive partners are often a barrier to women entering treatment. Additionally, the punitive attitude taken by the health and social service systems has meant that practitioners often do not share information related to risk factors, or discuss substance use with women at risk in an effective way. Additionally, if a practitioner does notice warning signs for risk factors, it goes unmentioned to other practitioners involved in her care. An understanding of how people change is essential. Beyond helping women make change in their substance use, successful programs help women to get prenatal care, good nutrition, and safe places to live. They help them learn parenting skills and reduce the many stresses in their lives. Research has shown that all of these related changes do reduce the risk of alcohol- and drug-related birth defects in children, even when the mother does not manage to abstain from substances.

There are programs available to support birth, foster, and adoptive families with FASD affected children. The FAS/E Support Network of BC is an excellent first point of contact for parents dealing with an FASD affected child (604-507-6675, <http://fetalalcohol.com>, info@fetalalcohol.com). They provide information, support, and education for families, professionals, and the broader community, with a focus on both prevention and intervention. The Sunny Hill Health Centre for Children, located in Vancouver, provides screening for FASD, as well as acute rehabilitation services if required (604-453-8300). Sunny Hill uses a family-centred approach, supporting families and community service providers in their efforts.

There are also programs available for women at risk of having FASD affected children. BC Women's Hospital has a new program at Fir Square, which provides care for substance using women and their children. The unit also operates an outpatient clinic, and women are encouraged to schedule an appointment for this clinic by calling 604-875-2424 - local 2160 on weekdays.

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How much alcohol is safe?

Researchers have not been able to determine a safe level of drinking during pregnancy. The only completely safe course is **not to drink any alcohol at all** if you are pregnant or trying to become pregnant. However, different types of drinking affect the fetus in different ways. Binge drinking (drinking a lot over a short time) is more harmful than drinking the same amount over a week. This is because the mother's blood alcohol level is higher in the binge situation. Other factors may influence how alcohol affects the fetus, such as:

- the mother's health
- the mother's nutrition during pregnancy
- amount of alcohol consumed
- time during the pregnancy during which the alcohol was consumed
- the mother's metabolism

Drinking while breastfeeding is also harmful for the baby, since the alcohol in the mother's blood passes into the breast milk.

Source: Health Canada, FAS/E Support Network of BC

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Tobacco

Cigarette smoking is the most common addiction in Canada. 23% of British Columbians use tobacco regularly, which is similar to overall rates of smoking in Canada. In Northern BC, 30% of people use tobacco regularly. Every day in BC, 20 children try their first cigarette. It has been found that 83% of current smokers started smoking before the age of 19, so targeting youth is indicated as an effective way to reduce overall prevalence of smoking.

Smoking tobacco is also the leading cause of preventable death, killing 45,000 Canadians every year. In fact, smoking is responsible for 1 out of every 5 deaths in Canada, which is roughly 5 times the number of deaths caused by car accidents, suicides, other problem substance use, murder, and AIDS combined. The chance of dying from smoking for long-time smokers is 1 in 2.

The costs of tobacco smoking to society are enormous. In 1992 – over 10 years ago – a study estimated that the cost of illness related to tobacco smoking in Canada is \$9.6 billion every year. That's \$336 per year for every Canadian, at a very conservative estimate. These costs come from direct health care costs, and lost productivity due to illness or premature death due to smoking.

In British Columbia, 5,600 people die each year because of tobacco. And every year, BC loses more than \$1 billion to health bills, lost working time and other tobacco-related costs.

The damage done by smoking is not limited to people who choose to smoke. Second-hand smoke is also a major cause of preventable illness, and is estimated to kill about 500 non-smokers a year, just in BC.

Cigarettes can also harm babies of mothers who smoke. Such babies can have lower birth weight, are shorter in length, and have small head circumferences. Some studies link smoking with miscarriage and stillbirths. There is also evidence that smoking during pregnancy increases the risk of sudden infant death syndrome (SIDS).

Smoke from cigarettes contains over 4,000 chemicals that are cancer producing, including nicotine, tars, and carbon monoxide. Nicotine is a stimulant that is highly addictive. It stimulates the brain and central nervous system, which smokers may interpret as a feeling of relaxation. However, this stimulation contributes to the strongly addictive nature of smoking. Almost everyone who smokes develops a dependence on nicotine. Smoking tobacco is probably the most difficult addiction to overcome, even more difficult

than heroin.

The body adjusts chemically to having nicotine present in the system. When you then stop smoking, your body has to work to repair itself. While this is happening, you may experience withdrawal symptoms, such as: changes in mood; changes in sleeping patterns; changes in eating habits; cravings for nicotine; itchy hands or feet; stomach pains; coughing or dry mouth; dizziness; or headaches. Every smoker is different, some don't have any withdrawal symptoms, others may experience symptoms that range from mild to very uncomfortable.

The good news is withdrawal symptoms are temporary. They usually peak within a day or two, and last about a week (although they can last up to four weeks). If necessary, you can talk to your doctor about nicotine replacement therapy such as a patch or nicotine gum, which may ease the symptoms. You can also call the BC Smoker's Helpline at 1-877-

Effects of Smoking Tobacco

Immediate effects:

- Increased pulse rate
- Increased blood pressure
- Faster and more shallow breathing
- Drop in circulation
- Skin temperature goes down
- Nicotine stimulates the brain and nervous system (this feeling is often mistaken for relaxation)
- If you are allergic or asthmatic, flare-ups or chest spasms can begin quickly

Short-term effects:

- Higher blood pressure
- Increased susceptibility to colds and pneumonia
- More stomach acid is produced
- Less urine is produced
- Decreased appetite
- Decreased physical endurance

Long-term effects:

- Increased risk of serious health problems like heart disease, stroke, and lung cancer
- Emphysema is often associated with smoking, and is a life-threatening disease in which the lungs are abnormally enlarged
- Chronic bronchitis and cancer of the larynx, mouth, bladder, kidney, and pancreas are common in people who have smoked heavily for years
- Chronic shortness of breath

Source: Alberta Alcohol and Drug Abuse Commission

455-2233 (10am to 6pm, Monday to Friday, closed on holidays).

A study carried out in the Department of Preventative Medicine at Kaiser Permanente, in conjunction with the US Centre for Disease Control and Prevention, has found that people who have experienced adverse childhood experiences (such as physical, sexual, or emotional abuse) are up to three times more likely to smoke than those who have not had such adverse experiences in childhood. This study also found that over 12% of people with four or more such experiences had initiated smoking by the age of 14, compared to approximately 4% of the general population. This finding has important implications for determinants of health later in life, since so many adult smokers begin smoking in their teenage years.

There is also evidence to suggest that people with mental disorders are more likely to smoke than the general population. An American study in 2000 found that one half of all cigarettes are consumed by people with mental illness. While roughly a quarter of the general population smokes, people with depression or anxiety are twice as likely to smoke. A startling finding is that 88% of people with psychotic disorders such as schizophrenia are smokers.

Many speculate that in this correlation the mental disorder comes first, and many people take up smoking or increase the amount they smoke in order to calm their distress. However, there is increasing evidence that suggests smoking may cause clinical depression and several forms of anxiety disorders. A US study that followed the health of over 15,000 adolescents for a year made some



remarkable findings. Teenagers who started out mentally fit but smoked at least one packet of cigarettes per week during the study were 4 times more likely to develop depression than their non-smoking peers. Another researcher found that smokers are 4 times more likely to have an isolated panic attack than non-smok-

ers. While these findings do not prove that smoking *causes* these mental disorders, the co-occurrence identifies some risk factors that may assist in prevention and early intervention of both smoking and mental disorders.

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Benefits of Quitting

When you quit smoking tobacco, the benefits are both immediate and longer-term. You can expect:

Within 20 minutes... blood pressure and pulse rate return to normal

Within 8 hours... the oxygen levels in your blood return to normal

Within 1 day... your risk of having a heart attack decreases

Within 2 days... nerve endings start regrowing, and senses of taste and smell are enhanced

Within 2-3 weeks... circulation improves (you may notice warmer hands and feet)

Within 3 months... your lungs will be more efficient

Within 12 months... circulation and lung function improve, walking becomes easier

Within 18 months... your risk of having a heart attack is almost as low as that of a non-smoker

Within 10 years... your risk of dying from cancer is equal to that of a non-smoker

Within 15 years... your risk of dying is similar to that of a person who has never smoked

Source: Alberta Alcohol and Drug Abuse Commission

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Suicide: Follow the Warning Signs

Though BC's suicide rates have remained fairly stable over time, roughly 500 per year, suicide rates in Canada have been rising sharply for nearly five decades. Suicide deaths in Canada numbered 4074 in 1999, up 10% for both sexes from the previous year — the biggest percentage increase since the mid-80s. By contrast, there were fewer than 500 murders and about 3000 motor vehicle accidents.

A closer look at the figures reveals that suicide strikes hardest at the young, the elderly and other vulnerable members of society. For example, Canadian seniors have among the highest suicide rates in the country. In 1998, of all age groups in Canada, men over the age of 85 had the highest rate of completed suicides. In BC in the year 2000, the suicide rate for all men averaged out to 17.5 deaths per 100,000 people; men over 85 had double that rate. Major illness, the death of a spouse, a shrinking circle of friends — all contribute to stress and depression which can lead to suicide and suicidal behavior.

Canada's youth are another group of Canadians at high risk for suicide. Between 1959 and 1999, the Canadian suicide rate for 15- to 19-year-olds rose from just under two deaths per 100,000 people to just over 12 — an increase of more than 600%. This makes suicide the second-leading cause of death among young people in Canada, in BC and worldwide. In 2000, 70 young people aged 15-24 took their own lives in BC.

Like the elderly, the majority of adolescents who commit suicide have related mental health issues, including depression, substance use problems and eating disorders.

The increase in suicidal behaviour among Canada's youth indicates that many adolescents feel they should be able to handle their mental and emotional issues on their own. Suicidal youths may be reluctant to turn to others for help, having learned from their role models not to rely on others.

Adolescent and adult suicide rates are even higher in First Nations communities. Deteriorating quality of life in some Native communities may play a role particularly among people with clinical depression, sexual abuse histories, problem alcohol and drug use and limited family support.

One exception to this trend is the low suicide rate among First Nations elders. In many cases, these elders may be less likely to take their own lives because, traditionally, their cultures have valued and respected them for their wisdom.

Other ethnocultural communities also ex-

perience variations in suicide rates compared to the general population. For example, among immigrants to BC born outside Canada, those from India are the visible minority presenting the highest suicide rates. Furthermore, suicides are disproportionately higher in young married women than in single women.

Mental health problems are the common thread in all groups with a high risk for suicide. Studies indicate that as many as 90% of people who commit suicide are experiencing depression, an addiction or other diagnosable disorder when they take their own lives.

People with major mental disorders who attempt or commit suicide do so not out of a desire to die, according to one researcher, but out of a desperate need to put an end to their own suffering.

Allan, 32, developed post-traumatic stress disorder as a result of his childhood sexual abuse history. He says he began to think of suicide at the age of 12, but didn't attempt it until he was 20 years old when he swallowed a bottle of sleeping pills.

About an hour later, he "started thinking about other people, and having feelings again." Allan says these feelings prompted him to call a cab and ride to the nearest hospital. There his stomach was pumped and by the next afternoon, Allan was free to go home. However,

Warning Signs of Suicide

- recent attempt or other form of self-harm
- talking or joking about suicide, what it would be like to die
- risk-taking behaviour
- deliberate self-harm, e.g. cutting oneself
- expressing feelings of hopelessness about the future, e.g. "What's the use?"
- withdrawal from friends, family members or activities
- substance use problems or other addictive behaviours (e.g. compulsive gambling)
- self-neglect (hygiene)
- hears voices instructing them to do something dangerous
- a history of suicidal gestures or attempts
- following social withdrawal, the person reverts to unexpected positive behaviour, showing an increased interest in family activities, friends or work
- giving away treasured keepsakes; making a will
- questioning own value and worth, e.g. "I'm no good to anybody"

Suicide Rates in Canada

- deaths reported as suicides (4,074) were up a sharp 10% in 1999 – the biggest percentage increase since 1986; 80% of those suicides were men.
- it is generally acknowledged that both the stigma attached to suicide and the misclassification of deaths and injuries as accidental rather than intentional contribute to an underreporting of suicide and suicide attempts.
- in Canada, there are approximately four male suicides for every female suicide, but women are more likely than men to attempt suicide
- suicide rates in Canada tripled between the 1960s and 1980s
- seniors are responsible for approximately 12% of all suicides in Canada
- 10-15% of people with mental disorders commit suicide
- up to 90% of people who have committed suicide had depression, problem substance use, and/or a diagnosable disorder
- In 1999, Canadians were more than eight-and-a-half times more likely to die from suicide than to be the victim of a homicide
- the average cost of hospitalization for suicide and attempted suicide is \$5,500 per admission and can range from \$3,000 to \$31,000 depending on the length of stay, type of hospital and whether the patient died in hospital. In 1997, suicide cost Canadian hospitals \$100 million

he recalls, "I didn't feel anything that day. I didn't feel anything. I just knew I was alive."

In most cases involving suicide, the act itself is not an impulsive decision. In fact, most people who attempt suicide talk about it beforehand without any immediate plans to carry it out. Most people who die by suicide give some indication of their intentions prior to killing themselves; one third leaves a note.

Some people also make suicidal gestures: self-destructive acts that a person associates with suicidal feelings. These actions may include taking a dozen aspirins or making surface cuts on one's wrists. Although these acts do not necessarily result in physical damage, all suicidal behaviour should be treated as a cry for help.

People who are contemplating suicide are deeply troubled, either from real life circumstances or from delusions and/or hallucinations. This is reflected in the various warning signs they give, says the CMHA.

Fortunately, immediate intervention and ongoing support can help a person recover from

despair and reconnect with their own self-worth. If other people notice and act on the warning signs, they may have an opportunity to save a life.

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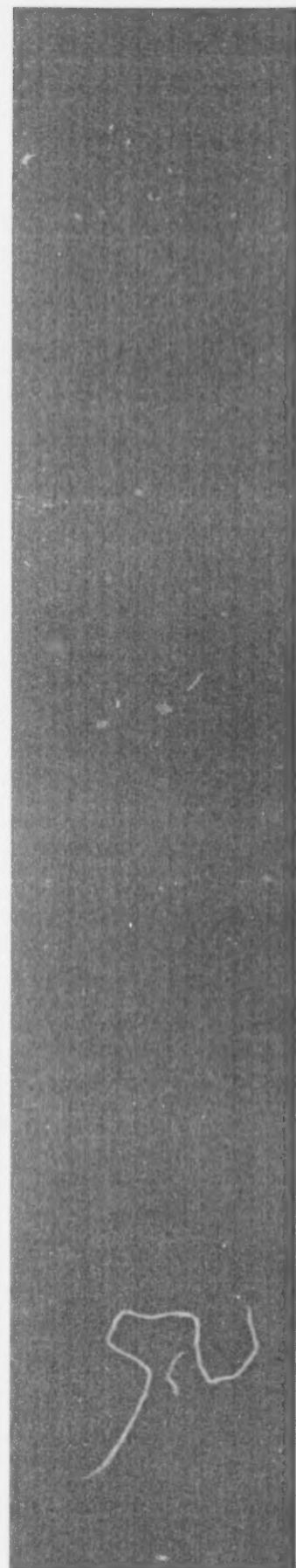
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Suicide Prevention Initiative, Mental Health Evaluation and Community Consultation Unit

How to Help Someone With Thoughts of Suicide

- remind yourself that all talk of suicide must be taken seriously
- say to the person:
 - "It's reasonable to feel as you feel, but I can help you find other solutions"
 - "You are really important to me"
 - "I don't want you to die"
- if you are concerned about suicide but the person hasn't talked about it, ask a direct question without putting the idea into the person's head (e.g. say "Are you thinking about suicide?" rather than "You're not thinking about suicide are you?")
- phone your local emergency number; remember that confidentiality can be waived in life or death situations

Source: Canadian Mental Health Association



More Suicide Facts

- yearly number of completed suicides worldwide: 1 million
- estimated number of attempts for every completed suicide: 20
- the mental disorder most commonly leading to suicide: depression
- the single most accurate predictor of a person's likelihood to attempt suicide: hopelessness
- percentage of gun deaths that are suicides: around 80%
- the potential years of life lost due to suicide each year: 15,000
- proportion of suicide victims in Alberta in 2001 with a record of gambling: 10%

Source: World Health Organization and MHECCU

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Crisis Lines in BC

Greater Vancouver

- Vancouver: (604) 872-3311
- Vancouver – for students: (604) 822-3700
- Coquitlam/New West: (604) 540-2221
- Richmond: (604) 279-7070 (English); (604) 278-8283 (Cantonese); (604) 279-8882 (Mandarin)
- Surrey: (604) 951-8855

Fraser Valley

- Abbotsford: (604) 852-9099
- Chilliwack: 1-877-820-7444
- Mission: (604) 820-1166; Teen line is (604) 462-7900

Vancouver Island

- Victoria: (250) 386-6323
- Campbell River: (250) 287-7743
- Courtenay: (250) 334-2455
- Cowichan Valley: (250) 748-1133
- Parksville/Qualicum: (250) 248-3111
- Nanaimo: (250) 754-4447
- Port Alberni: (250) 723-4050 or 1-800-588-8717
- Port Hardy: (250) 949-6033

Okanagan/Kootenays

- Cranbrook: (250) 426-8407
- Kelowna: (250) 763-9191
- Penticton: (250) 493-6622
- Trail: (250) 364-1718
- West Kootenays: (250) 364-1718 or 1-800-515-6999
- Vernon: (250) 545-2339; Teen line is (250) 542-8336

Northern BC/Cariboo

- Fraser Lake: (250) 669-6315
- Prince George (serving Houston to the Queen Charlotte Islands and north to BC/Yukon border): (250) 563-1214 or 1-800-562-1214; Teen line is (250) 564-8336 or 1-800-564-8336
- Northeast region: 1-877-442-2828
- Quesnel: (250) 992-9414
- Terrace: (250) 635-1911
- Williams Lake: (250) 398-8224

Source: BC Crisis Line Association

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Treatments for Mental Disorders

While there are no known cures for mental disorders, new medications and other therapies are becoming more effective at reducing the mental, emotional and physical impacts of mental illness and restoring people's quality of life.

For some people, treatments may alleviate many or all of the symptoms of mental illness, whereas for others, treatment may offer little or no relief. Researchers do not know why treatments help some people and not others, nor can they predict who will benefit from medications and who won't.

Physicians do know that early intervention is the key to recovery. This means encouraging people to visit their family doctor

Common Treatments for Mental Illness

Medications:

- antidepressants
- antipsychotic drugs
- anti-anxiety drugs

Therapies:

- **cognitive therapy:** helps people recognize and change thinking patterns that are not beneficial
- **behavioural therapy:** helps people recognize specific behaviours that are harmful and replace them with positive behaviours
- **interpersonal therapy:** helps a person re-evaluate how they relate to others and deals with specific issues (e.g. grief, conflicts, transitions from one social or occupational role to another)
- **relaxation therapy:** helps a person develop skills to release tension in the body and mind

Groups:

- peer support groups
- family support groups
- group counseling

Lifestyle changes:

- regular exercise and proper nutrition
- increasing social activities
- abstaining from drugs and alcohol
- reducing intake of sugar, caffeine and nicotine

Source: Canadian Mental Health Association



at the first signs of a mental health problems rather than waiting for the illness to develop into a crisis situation or psychiatric emergency.

For many people, more than a year passes between the onset of symptoms and a medical diagnosis and treatment (Diagnosis is a medical term that describes an illness according to the presence of various symptoms). Left untreated, a person with a mental disorder has an increased risk of experiencing significant deterioration in occupational and social skills.

On the other hand, doctors often hesitate to label the illness too early, since symptoms of mental and physical illnesses may be similar. For example, physical illnesses such as epilepsy, brain tumours, thyroid and other metabolic disturbances may involve symptoms that resemble mental disorder and must be ruled out before a psychiatric diagnosis can be made.

Once the illness is identified, a physician may prescribe medication and/or psychotherapy or refer the person to a specialist who can establish an appropriate treatment plan.

Treatment for major mental illness usually involves a combination of medication, lifestyle changes, psychotherapy and supportive counseling for the person with the illness as well as their friends and relatives.

Some people can recover with psychotherapy alone. For others, the right medication coupled with attention to self-care eases symptoms although finding the right medication and the proper dosage is usually a matter of trial and error since every person reacts differently to medications. The amount of medication required to treat symptoms

Fast Facts on Pharmaceutical Treatment in BC

- Medications for mental illness in BC have risen faster (up 152% over the last 10 years) and represent a larger proportion (34%) than any other category of prescription medications
- 2.8 million prescriptions were filled for antipsychotics, antidepressants, and anti-anxiety medications in BC in 2000
- in 1999; and the number of patients in BC taking psychiatric medications has increased 40% over the last 10 years

Source: Pharmacare and IMS Health

effectively may vary widely depending on the person's gender and ethnic background, for example.

Since all medications have side-effects, the best medication is one that offers the most benefits combined with the least discomfort for the person receiving treatment.

Maurizio Baldini, 44, is a mental health advocate and former lawyer with schizophrenia. He says that when he was first prescribed antipsychotic medications in the 1970s, the side-effects were debilitating. "My muscles became rigid, my vision blurred and I slept about 20 hours a day... the so-called negative symptoms [of schizophrenia] such as lack of motivation and depression actually got worse and were made more severe by the medication," he says. Times have certainly changed. In a 2001 Schizophrenia Society of Canada report, most people with schizophrenia rate their medication with an average 8 out of 10 marks. Half of the survey participants admitted stopping their medication for extended periods and only a third of those cited side-effects as the major reason for discontinuing medication.

Baldini's side-effects improved with a smaller dosage and the advent of newer medicines which have kept his disease at bay for 13 years. "I'm for the lowest possible dosage of the best possible medication," he says, adding, "In some ways I see myself as lucky because medications work for me."

The last two decades have seen dramatic advances in treatments for mental illness, particularly the advances in antidepressant and antipsychotic medications.

Psychotherapy has also improved over the years. For example, people with disorders ranging from depression to anxiety disorders to schizophrenia may benefit from cognitive-behavioural therapy, a technique that helps people recognize and change thinking patterns that are not beneficial to themselves and others.

Research has shown that many patients

with Seasonal Affective Disorder (SAD) — clinical depression only during autumn and winter seasons — improve with light therapy which is exposure to bright, artificial light for as little as 30 minutes per day. Light therapy leads to significant improvement in 60% to 70% of SAD patients. The treatment is also currently being tested for use with postpartum depression.

Peer support groups can help remove the social barriers that mental illness can create, and provide a safe place for people with these illnesses to share their experiences and feelings.

Some people with mental illness may also benefit from alternative therapies ranging from herbal remedies and art therapy to cranio-sacral therapy (a form of therapeutic touch). Many people prefer to explore non-pharmaceutical options first, while others turn to alternative therapies when traditional treatments prove unsuccessful. It should be noted, however, that the benefit claims of most herbal formulations or alternative remedies are not as well supported by empirical research as antidepressants, counselling or light therapy are.

A spiritual dimension is an important part of recovery and often especially so for many people from diverse ethnocultural communities who understand mental health from a holistic perspective and include complementary therapies as part of treatment for mental disorders.

Family support is another key element of a treatment plan. One of the best predictors of recovery is the presence of people who believe in and stand by an individual with mental health needs.

Given the trend towards deinstitutionalization over the last 25 years, the role of the family may be more crucial than ever. In some cases, an individual with significant mental illness has nowhere else to turn to for

Alternative and Experimental Treatments for Mental Illnesses

- sleep deprivation for bipolar disorder (manic depression)
- herbal extracts of St. John's Wort (*Hypericum perforatum*) for depression
- music, art and play therapy
- light therapy for postpartum depression
- biofeedback
- repetitive transcranial magnetic stimulation (rTMS)
- aromatherapy
- acupuncture
- therapeutic massage
- homeopathy or naturopathy
- Ayurvedic medicine

care and housing since long-term hospital care is seldom an option today. Family members can also play an important role in the diagnostic process. Since they are often the first to notice signs of mental illness, they can assist their relative in seeking help.

The earlier the person receives treatment, the better. Research shows that timely and appropriate treatment can greatly improve the symptoms of major mental disorders and reduce the chances of a long term psychiatric disability. The challenge to parents, teachers, peers and family members is to recognize the signs and symptoms early so the person can get the most effective help. The challenge to mental health educators and the health community is to better communicate the reality of recovery. A 2003 Canadian Mental Health Association survey, for example, found that only one-third of Canadians are aware that new treatments for depression and anxiety are more effective, safe and tolerable, and only 12% believe that medication can actually help someone with depression or anxiety live symptom-free, as opposed to just cope better with their symptoms.

Though full recovery is possible, in many cases ongoing treatment and support are needed to help a person manage their symptoms, resume their normal activities and prevent future relapses. Nevertheless, mental illness does not rule out activities such as sports, education, work and social involvement, says the CMHA. Over 80% of individuals with depression can be successfully treated and return to activities they previously enjoyed.

For Baldini, an ongoing treatment plan consists of medicine combined with regular exercise, a healthy diet and adequate sleep. "Even the stress of a full-time job doesn't affect my mental health if I maintain a balanced life," he says.

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Alternative Treatments for Mental Disorders

In BC, doctors routinely prescribe medications for people with depression, anxiety disorders and other mental disorders. But the widespread use of medications doesn't mean that drugs are the only option for treating mental illness, according to the Canadian Mental Health Association (CMHA).

"We encourage people with mental illnesses to explore both traditional and alternative forms of treatment," says Grainne Holman, from the Health Promotion Department of the association's Vancouver-Burnaby branch. "Some people with major depressive disorder find that antidepressants and/or cognitive therapy is the best route, but people with milder depression sometimes feel better with regular exercise or a change in diet, for example." Cognitive therapy is based on research showing that people can alter their emotions and even improve their symptoms by re-evaluating their attitudes, thought patterns and interpretations of events.

Although she doesn't advocate any specific therapy, Holman says many people with mental health needs are discovering that alternatives ranging from biofeedback to music therapy can help restore peace of mind. "People need to be aware that these alternatives exist," says Holman, but she cautions: "they also need to know how to evaluate existing information about how effective they are, and about whether there are any adverse effects when alternative treatments are taken together with traditional treatments."

Jane, a 30-year-old biologist who didn't want to use her real name, takes 900 mg a day of St. John's Wort, an herb that has been routinely prescribed for depression in Germany for decades. A recent large-scale research review indicates that the herb may offset physical symptoms of clinical depression. However, the herb is still undergoing safety tests that explore possible herb-drug interactions and side-effects. Consumers should also be aware that the concentration of active ingredients in herbal formulations may vary from one manufacturer to the next, therefore, it is best to seek the advice of a naturopath about the most reputable brands for a specific purpose. Jane says she likes the herb because it is inexpensive and available at local health stores unlike prescription antidepressants which she tried for two months.

"One thing that makes me feel better about St. John's Wort is the fact that I'm in control of it," she says.

Michael Koo, 34, who has had depression for at least a decade, agrees. He says the keys to his recovery are reaching out to others, expressing his feelings and taking time to connect with his body. "It involves stretching, breathing, making sounds and getting up and dancing to music, especially with other people," says Koo. "It's going back to what animals already do."

Biofeedback is a technique that helps people tune into their own body sensations and learn to control many of their own bodily functions including blood pressure, heart rate, skin temperature, and muscle, according to Clayton Tucker-Ladd, author of *Psychological Self-Help*. A person with panic disorder, for example, might be able to use biofeedback to identify the sensations of the body's "fight-or-flight" response and may eventually learn to nip a panic attack in the bud, he notes. Some individuals who have failed to benefit from first-line treatments (cognitive-behavioural therapy or medications) may find this technique helpful in reducing the physiological symptoms of anxiety.

Other people seek religious and spiritual help for their mental health problems. Although he doesn't believe in God, Allan, 31, says developing a spiritual awareness has helped him recover from the effects of a major depression, suicide attempt and a history of physical and sexual abuse. "Basically, spiritual meditation has been really helpful in just connecting with the energy around me," he says. A recent study by Harvard Medical School found that more than 10% of individuals with depression or anxiety disorders sought care from members of the clergy.

Alternative and Experimental Treatments for Mental Illnesses

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- herbal extracts of St. John's Wort (*Hypericum perforatum*) for depression
- music, art and play therapy
- light therapy for postpartum depression
- biofeedback
- repetitive transcranial magnetic stimulation (rTMS)
- aromatherapy
- acupuncture
- homeopathy or naturopathy
- Ayurvedic medicine
- therapeutic massage

BC's Ten Most Common Alternative Therapies Used in the Past Year for Health

Of the 84% of study participants in BC who said they had used at least one alternative therapy in their lifetime, the most popular remedies include:

1. Chiropractic
2. Massage
3. Herbal therapies
4. Relaxation techniques
5. Prayer
6. Yoga
7. Folk remedies
8. Lifestyle diet
9. Acupuncture
10. Special diet programs

Source: The Fraser Institute

gy. There are also a number of other studies showing an association between spiritual practices and better health and mental health.

People with more serious mental illnesses such as schizophrenia may benefit from a combination of medication, cognitive therapy, music and art therapies. Cognitive therapies provide tools for reinforcing psychoeducational concepts and dealing with persistent symptoms such as hallucinations. Once considered to be "alternative therapies," cognitive therapies for people with psychotic disorders are increasingly being supported by clinical research and incorporated into mainstream mental health care. Music and art therapies allow people to explore their feelings through art and music, make positive changes in mood and emotions and develop self-esteem through participation in creative activities. "The body's physiology changes from one of stress to one of deep relaxation, from one of fear to one of creativity and inspiration," according to Michael Samuels, a medical doctor and art therapist. In BC, creative arts are part of treatment programs at BC's Riverview Hospital, Vancouver Community Mental Health Services and others.

Alternative treatments are not a cure-all, especially for people with more serious mental illnesses. But it is important for people to have a sense of choice when it comes to treatment, says Holman of the CMHA. "We tell people to trust themselves and trust their own physical and emotional reactions to different treatments, no matter how helpless they have been made to feel. We want them to find the combination of alternatives that works for them."

In addition to their treatment choices, people with mental illness benefit from a holistic approach to community support, she adds. Community services should address the issues of income, housing and employment, and provide services offering peer-based and self-help support, says the CMHA.

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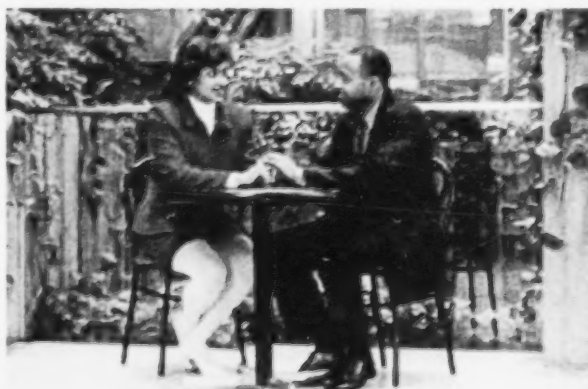


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Treatment for Addictions

When Tom finally realized that his drinking problem was out of control, he wondered about going for treatment... and then he wondered about treatment. Is it a place where you try to change by living in a controlled environment? Is it a process that you go through so that you come out clean and sober at the end? Is it necessary? Does it help?

These are good questions. Treatment is not simply a place or a process. It can lead to sobriety, but that might not necessarily be the goal. It's also not just for out-of-control use of substances or behaviours. And while it isn't necessary for change, it can help a great deal.

To really understand what treatment is, and also what it can be, we first need to be clear about what it's *for*. Many people think that treatment is for addiction. Addiction is use of a substance or behaviour that is characterized by preoccupation with one or more substances or behaviours, loss of control, and continued use or involvement despite negative consequences.

In fact, treatment is meant to address problem use of substances or behaviours along a spectrum where addiction is just *one* type of problematic use. The range of this spectrum extends from potentially problematic use through use that involves negative consequences to full-blown addiction as described above.

At any point along this spectrum, it is possible to intervene in a way that reduces existing harm to self and others and prevents further harm. Such interventions aim to heal the person as a whole. This means that rather than just addressing substance use, treatment interventions also need to address other problems the person is experiencing or has experienced. These problems may have either led to or arisen from the substance use.

In very general terms, we can define treatment as any and all interventions designed to help people deal with problem use. But answers to a number of key questions help shape what we mean by treatment.

What causes substance use problems?

In order to treat a person experiencing problem substance use, we need to understand the factors that contribute to problem use. Many people use substances without any adverse ef-

fects, but some develop problems arising from substance use that range from mild to severe.

The addictions field in British Columbia has embraced a bio/psycho/social/spiritual model to explain problem use. This approach takes into account the ways that various dimensions contribute to use, and are affected by use:

The **biological** dimension is the physical aspect of problem use, including possible genetic or physiological predispositions to addiction, as well as the physiological effects of addiction on the body, brain, and nervous system. Most of these effects relate to the dependence on substances and behaviours that people can de-



velop, and the cravings they can experience in withdrawal or reduction of use.

The **psychological** dimension refers to a host of possible issues that can contribute to the development of problem use, as well as the psychological effects of using in a way that increases dependency. Contributing factors may include difficult childhood histories, experiences of trauma, and mental health problems that leave people with underdeveloped resources to deal with life's challenges. Psychological effects that deepen dependency include the intense pleasure of using as well as the depression, anxiety, stress, and/or inability to experience pleasure that sets in between experiences of using.

The **social** dimension concerns the influence of family members, friends, peers and society in the development of attitudes, values and beliefs that can contribute to problem use, usually through modelling and peer pressure. It also centrally concerns the problems that people have relating to others. Whether this is due to underlying psychological issues, shyness, poor modeling, or underdeveloped social skills, hav-

ing trouble relating to others can contribute to the development of problem use. Over time, problem use can also further impact these skills by replacing social contact with a more exclusive relationship with a substance or behaviour. This can rob a person of the opportunity to develop as a fully social being.

The **spiritual** dimension refers to a meaningful connection with life that transcends daily concerns and goals and nourishes the spirit. In many cultures, and throughout history, substances have been imbued with spiritual significance and valued for this reason. Many people in contemporary society lack a sense of meaning and feel disconnected. Some turn to using substances in an attempt to regain this sense of meaning and connection. However, substances which at first appear to provide meaning and a sense of connection can actually lead to alienation if problem use develops.

Particular programs or individuals may place extra emphasis on one or another of these components. While one factor may be a dominant contributing factor to an individual's problem use, it is worthwhile to consider all four dimensions when considering treatment.

Who is treatment for?

Historically treatment has chiefly focused on the individual user. However, problem use and treatment exist within a broader context. For one thing, the biological, psychological, social and spiritual dimensions of problem use do not develop in a vacuum, but rather in relationship with families, peer groups, communities, and society. These environments can create or worsen conditions for the development of problem use. Second, the impact of problem use extends far beyond that of the individual. These same groups are in fact harmed by problem use in relation to a host of health issues, psychological concerns, social problems, crime, and economic impact. For these reasons, we

can think about treatment as including interventions designed to help individual users as well as those that are designed to help families, peer groups, communities, and society.

What are the goals?

The addictions system in BC has embraced harm reduction as its foundational guiding principle. This means that services, in the process of helping people change, are guided by the aim of minimizing the harm to all individuals and communities. One strong advantage of this approach is that degrees of success can be measured in terms of harms diminished. Under this view, the system recognizes that a single kind of treatment cannot fit the needs of all individuals with problem use or communities that are impacted by use, at all stages of change.

With harm reduction as an overarching goal and philosophy, various other goals may be appropriate for individuals at different stages of change. A medical approach may be used with the goal of stabilizing the person to allow them to address other issues. This may involve management of addiction with medications that can reduce craving, replace one drug (e.g., heroin) with another (e.g., methadone), block the effect of a certain drug, cause unpleasant reactions when a substance is used, or improve one's psychological health. On the other hand, abstinence is an appropriate goal for many clients and practitioners, but attaining it may require the short-term adoption of other goals such as reducing use and increasing health, in order to minimize the harm.

Who makes the changes?

Traditionally, the responsibility for healing was in the hands of trained professionals, with the assumption that people benefit most from expert advice and interventions. This approach is quite common in the fields of medicine, mental health, and addiction. More recently there has been increased emphasis on self-manage-

Treatment options in BC

Treatment for substance use problems may involve one or more treatment modalities such as psychoeducation, pharmacotherapy (use of medication), behaviour therapy, counselling and psychotherapy, traditional healing practices, and 12-Step-based programs. These modalities may occur within various treatment components within the system of care.

- **Outpatient treatment** – available in most communities
- **Multi-component programs for youth** – various constellations, vary by region
- **Withdrawal management** – residential, home, or outpatient support during withdrawal
- **Intensive non-residential treatment** – day or weekend programs, clients live at home
- **Residential treatment** – intensive treatment in a structured residential context
- **Supportive recovery services** – longer-term transitional housing and support services
- **Pregnancy Support Services** – support services to at-risk pregnant women and their families
- **Street outreach programs** – support services and bridges to the system of care
- **Needle Exchange programs** – prevent disease transmission and provide bridges to services
- **Methadone treatment** – replacement therapy for heroin addiction
- **Safe supported housing** – housing with associated support services



Photo Courtesy of Microstock

ment. Trained professionals and experts are seen as helping people change, rather than "fixing" them. People are no longer seen as passive recipients of treatment, as there is an assumption that the most effective treatment empowers people to determine what and how they would like to change.

It is important to note that self-management does not imply a do-it-yourself model of change. It should involve a collaboration between clients and practitioners that empowers and supports people to make the kinds of changes they want to make in order to reach treatment goals. In the case of addiction, collaboration optimally entails intensive and coordinated involvement with teams of professionals across various sectors of health, mental health, social services, community organizations, addiction services, law enforcement, corrections, and law. This kind of collaboration of course also optimally applies not only to meeting individual goals, but also to the goals of families, peer groups, communities and society in preventing problem use and reducing harm.

How does change happen?

For some time, treatment experts believed that real change in people's lives could occur only after abstinence was achieved. Once their focus was shifted away from use of substances or behaviours, people could then be supported to reconstruct their lives.

The philosophy of harm reduction has radically changed this conception. For many experts, abstinence is still the preferred ultimate goal. However, for many people abstinence may not be a realistic goal, especially at the outset of treatment. Moreover, there is a great deal that can be accomplished under the heading of treatment that can help people make increasingly healthy choices about their use of substances and addictive behaviours.

For example, just providing simple information about the amount of alcohol in a standard

serving of wine, beer, and spirits can help people make decisions about what and how much they drink. To take another example, motivational interviewing is a special counselling technique that supports change in small increments over time. At a more fundamental level, people may need to be given the message that it matters whether they live or die, and therefore that it matters that they use clean needles and safer practices. Other people

may need to secure basic needs like safe housing and food before they can even contemplate other changes.

The point is that the path of recovery is varied and that evidence suggests treatment goals need to be individualized and grounded in the real life circumstances and situation of any given problem user.

Does treatment work?

Treatment success needs to be measured through improvements in the quality of life and health status of the affected individuals. Decades of research have established a variety of addiction treatment methods that are as successful as treatment for most other similar chronic conditions. These treatments include both behavioural therapy and medication. Recovery from dependence can be a lengthy process and frequently requires multiple or prolonged treatment episodes. Lapses during the course of treatment are common and do not indicate that treatment is ineffective. In fact, it is critical that lessons from lapses be identified and integrated into the treatment process. To be most effective, treatment must be readily available, tailored to individual needs, and part of a comprehensive plan that addresses associated medical, psychological, vocational, legal, and other social needs.

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Recovery from Mental Disorders

Although recovery has long been the goal of physical rehabilitation programs, the concept of recovery is relatively new in the mental health field, notes the Canadian Mental Health Association (CMHA).

Until a few decades ago, people with major mental illness were viewed as lost souls with no other option than institutionalization, sometimes for the rest of their lives.

The arrival of powerful anti-psychotic drugs in the 1960s provided relief from the more severe symptoms of mental illness, allowing people with major mental illness to live well outside of institutions.

The treatment philosophy of the mental health system has gradually shifted away from institutions and towards a community-based approach to mental health services. This resulted in massive closures of long-term care hospitals and the development of community treatment facilities — a process that continues today.

The vision of recovery from mental illness emerged in the 1990s when mental health care services began to focus on how people function rather than on how services were managed and delivered.

Today, more and more people lead active and meaningful lives in spite of the challenges associated with mental illness.

Maurizio Baldini, 44, has been maintaining his recovery from schizophrenia for 13 years. A former lawyer, he now works on legal issues as a mental health advocate. Baldini says he finds it rewarding to provide support to others. "I have a positive outlook on life and have been lucky enough to build a comfortable life for myself," he adds.

Patricia Deegan, a pioneer in the mental health recovery field, completed a doctoral degree after years of coping with major mental illness. Based in Lawrence, MA, Deegan emphasizes that people with mental illness are not passive recipients of rehabilitation services. They do not "get rehabilitated" in the sense that cars "get tuned up" or televisions "get repaired." Rather, they are courageous participants in a way of life that includes employment, social interaction, sports, community service and other activities.

She describes recovery as a non-linear process, one that involves disappointments and set-backs as well as sudden insights and periods of growth.

A person can move beyond a life defined solely by mental illness yet still have occasional symptoms just as a person with heart

disease can recover from surgery and adapt to living with a vulnerable heart.

For example, Baldini monitors himself daily in order to nip any symptoms in the bud. "I just make sure I get enough sleep and make sure I'm not too stressed out," he says, adding that he exercises regularly and follows a healthy diet. "If I can catch [an acute episode] in the early stages, I take a little medication and it usually clears it up."

Since early intervention is the best treatment, learning to recognize the early stages of a relapse is an important aspect of living with mental disorders.

Nevertheless, recovery from the illness is only one part of the process, according to Deegan. Many individuals with mental illness must also rebuild a sense of self-worth and recover from the side-effects of unemployment, long periods in treatment settings and the stigma and discrimination attached to mental disorders.

Reclaiming these aspects of life are sometimes more difficult than recovering from the illness itself, Deegan says. Crushed dreams may take a long time to mend especially if the person has had few opportunities to direct his or her own life.

For example, people with mental illness may face additional barriers to employment since these disorders often strike in early adulthood at a time when education and job skills are being developed. At the same time, the ability to participate in the workforce is the single most important factor in making a successful transition to the community at large, mental health advocates say.

Employment can provide income to improve one's housing situation, buy a warmer coat or pursue leisure activities that many people take for granted. Moreover, interaction with others in a workplace setting can motivate a person to learn a new skill, take

Activities that Support Recovery from Mental Illness

- opportunities to express one's true feelings
- social interaction with friends and colleagues with and without mental illness
- sports and leisure activities
- opportunities to resume education and learn new skills
- opportunities to join the workforce
- participation in community events and volunteer activities
- continued access to recovery programs, depending on need

Assumptions that Promote Recovery from Mental Illness

- **professional help is one factor in recovery:** e.g. help is also found through self-help groups, social support, adult education, meaningful employment, adequate housing, and self-care.
- **recovery can be everyone's business:** a key aspect of recovery is the presence of people who believe in and stand by the person in need of recovery
- **recovery may occur whether one views the illness as biological or not**
- **recovery is possible even though symptoms may reoccur:** the episodic nature of major mental illness does not rule out recovery
- **recovery reduces the frequency and duration of symptoms:** e.g. more of one's life is lived symptom-free
- **recovery is not a linear process:** unexpected growth or insights may follow periods of little change; a relapse does not mean progress is suddenly undone
- **recovery from the consequences of mental illness is sometimes more difficult than recovering from the illness itself:** e.g. dealing with stigma, lowered self-esteem, discrimination in employment and housing
- **successful recovery does not mean the person was never "really mentally ill":** because of the inaccurate assumption that people with serious mental illness, especially schizophrenia, cannot recover, people who do get better are sometimes wrongly believed to have been misdiagnosed

Source: William A. Anthony, Center for Psychiatric Rehabilitation (Boston University)

on more hours or pursue education, notes the CMHA.

The presence of people who care and believe in the person is another important factor in recovery, says Dr. William Anthony, executive director of rehabilitation at the Center for Psychiatric Rehabilitation at Boston University.

For Baldini, encouragement from others was pivotal to his return to university after his first acute episode of schizophrenia. "The support I got from my psychiatrist was really helpful," Baldini says, adding that his psychiatrist lowered the dosage of his medication to help him to concentrate better.

People with mental illness can also support each other. For example, peer support groups encourage people with mental illness to share their experiences and know they are not alone.

Available throughout BC, clubhouses and other community services provide opportunities for people with mental disorders to get together, share meals and develop social and work-related skills.

As they recover, people begin to focus on other interests and activities and the illness becomes just one of many aspects of their lives.

For Baldini, recovery is "being able to work in what I want to do. It's having a broad range of emotions ... It's the normal sorts of things one would hope for in a balanced lifestyle," he says

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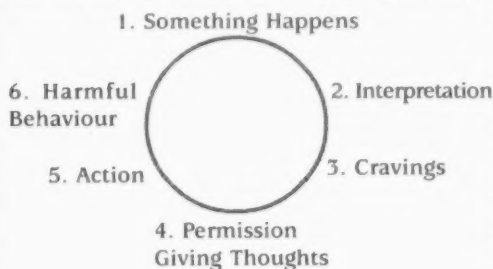
Addictions and Relapse Prevention

Many studies have explored relapse in persons with substance use problems. Relapse prevention describes the process of developing skills to continue your choice of health-promoting behaviours. In much of the literature this is assumed to be a choice to remain abstinent. Relapse prevention principles, however, can apply to any choice intended to reduce the harmful consequences of your behaviour. From these studies, three general conclusions can be drawn:

- You are most likely to relapse in the first three months after making a change.
- Your overall chance of relapsing is high.
- A relapse is not the end of the world – it is part of the natural cycle of change, a step on the way to lasting recovery.

How Does Relapse Happen?

Relapse does not begin with the adoption old behaviour, as one might think. Actually, falling back into your old pattern is the last step of the relapse process. Outlined below is one model of how a relapse happens. It is important to think about your own behaviour, and previous relapses that you may have experienced. If you are able to recognize the different steps of your relapse experiences, you will be better prepared to address this risk in the future. What is most important to recognize, is that the process provides you with opportunities to intervene at several points along the way.



Something happens: Sometimes referred to as a "trigger" the initial something can be an event, a feeling, a situation, or a person. It can literally be anything - good or bad, inside or outside you. A bad day at work, running into one of your old "using" friends, or achieving a goal and feeling proud and hopeful are all examples of the "something" that happens.

You interpret it: The something that happens triggers a core belief that you hold about yourself. This often comes in the form of a message that you say to yourself, consciously or subconsciously. These message beliefs are unique from person to person, but could be statements such as "I am a complete failure", "I don't deserve success" or "I need to celebrate."



Photo Courtesy of Microsoft

Cravings: These self-destructive interpretations lead to cravings. Cravings are the psychological and physical desire to engage in your old harmful behaviour (this may be smoking a cigarette, having a drink, going to the casino or any other harmful response you want to avoid).

Permission giving thoughts: Your cravings could lead you to thoughts that allow you to give yourself permission to engage in the old behaviour. These thoughts can take many forms. A few examples might be: "I need to smoke a joint to calm down", "I've been exercising pretty well. This weekend I'll just sit in front of the TV", "I deserve to treat myself, I've had a bad day", or "I have not been drunk for 3 months. I'm strong enough to handle going to that party."

Action: At this point in the cycle, you take the steps necessary to engage in the old pattern or give yourself an excuse for not engaging in your new pattern. This could be calling your old dealer, stocking up for the weekend, "dropping in" on a friend you know is always supplied, or inviting an old friend over so that you cannot make it to your exercise class.

Harmful behaviour: You finally engage in the old pattern (e.g. using a drug you had been abstaining from, getting drunk at a party, wasting the weekend in front of the TV).

The most important thing that you can do to avoid relapse is to develop a plan for your recovery. The most successful businesses have a clear mission statement, as well as a very fo-

Relapse Prevention

1. Set clear goals
2. Make commitments to yourself
3. Plan ahead!
4. Involve other people in your plans
5. Take care of your health – get plenty of sleep and eat balanced, nutritious meals
6. Practice those skills you are wanting to build into your recovery process
7. Evaluate your progress.
8. Reward yourself for your successes

Source: The Addiction Workbook

cused plan for how they will achieve their goals. It is equally important for an individual, striving to live a healthy lifestyle, to develop a plan to guide them towards success. A significant part of this plan, particularly early in the recovery process, is minimizing your risks for relapse.

High Risk Situations

Just about anything can be a relapse risk, and what may be the highest risk areas will differ greatly from person to person. The first step to take in your relapse prevention plan is to begin to identify those situations or circumstances that will be the highest risk factors for you. High risk situations can be that "something" that happens in the relapse cycle outlined above.

High risk situations can be internal or external in origin. Some examples of internal high risk situations can include: feeling depressed, boredom, loneliness, being tired, having that Friday afternoon excitement at the end of the day on payday, or pride over an accomplishment achieved. Some examples of external risk factors could include: an argument with your partner, a call from an old using friend, money stress, hearing a radio commercial, or a sporting or social event.

As you begin to reflect on your own life, it would be a good idea to make a list of your risk factors as you think of them, which you can continue to add to as time goes on. What things are most likely to happen in your life? What circumstances or events have been associated with your harmful behaviour? Your list doesn't need to be inclusive at this point; perhaps listing the first 5 or 10 risks that come to mind may be a good place to start.

Once you have created a list of your personal risk factors, it is time to develop a plan for each of these. Your plan should be very specific, and can consist of more than one response to each high-risk situation that you have identified. Here is an example of how this might look:

Phone call from Bob: I will state my abstinence commitment, and tell Bob I cannot see him any longer; I will take a clean friend with me and meet Bob at Starbucks for 30 minutes only; I will discuss with my sponsor.

Feeling Depressed: I will go for a 30 minute

walk; I will call people on my phone list, until I reach someone to talk to; I will write a list of 10 things that I am grateful for.

Developing a written plan helps in more than one way. It gives you an opportunity to commit your actions in writing to yourself. It allows you to be prepared, thus increasing your sense of control over the course of your own life. It also minimizes the likelihood that you will be caught off guard, which can be the most dangerous time for a relapse to occur.

Cravings

Cravings can occur in response to high-risk situations, or can occur of their own accord, triggered by a physical or psychological cue. Cravings, while not limited to, are most often associated with, substance use. Cravings can also occur during sleep, in what are sometimes referred to as "using dreams." This is when you may wake up and have the feeling that you have used your drug of choice. It is important for you to understand that when you experience physical cravings, the chemicals in your brain are involved. These chemicals can change in the same way they do when you use your drug of choice. Therefore, you may feel like you do either right before, or during drug use. It is common for people to feel their heart racing, experience a change in the taste in their mouth, or begin to sweat. It is important to understand this, and to know that these feelings will pass in a short period of time.

What is most important when you experience cravings, as with high-risk situations, is to have a clear plan for how you can respond to these cravings. Cravings are a natural and ongoing part of the recovery experience. They can continue to occur long after you have stopped

Phone Contact List

Name	Number
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____



using your drug of choice. Your brain needs time to develop new responses to the situations and events that triggered your drug use. The only way for these new responses to develop is for you to practice doing something different than using each time you experience a craving. Over time and with practice, cravings will occur less often, and feel less powerful, because you have developed different ways to respond to them.

Additional Ways to Support Your Recovery

While relapse prevention work is critical to the process of recovery, it is also important to build positive skills and patterns of behavior that support and enhance your recovery process. Here are some simple suggestions that you can explore to include in your recovery process:

1. **Healthy Eating.** If you eat well-balanced, nourishing meals, your body is better prepared to deal with daily stresses.
2. **Get enough sleep.** Sleep allows your body time to strengthen, rebuild and allows you to be clear headed and functioning at your best.
3. **Exercise regularly.** Exercise has many health benefits including building strength, increasing stamina, and lowering the risks for many health conditions. Exercise also helps you flush out toxins, and increases levels of endorphins, your "feel-good" hormones, both of which are beneficial to relapse prevention.
4. **Stay connected.** It is important to have positive social contacts in your life, both on the phone and in person. Work at building a network of people who support your recovery goals, and include them in your recovery plans.
5. **Practice meditation or relaxation skills.** Stress, anger, frustration or boredom are all potential risk experiences. Re-

laxation skills such as meditation are great ways to combat negative feelings.

6. **Journaling.** Writing down your thoughts, experiences and discoveries can be a powerful practice.

7. **Self-monitor.** It can be useful at the end of each day to evaluate how you are doing. What went well? What

would you have liked to have done differently? What did you accomplish today? What feelings did you experience throughout the day? These kinds of questions can be useful to continue to shape your plan for your own recovery.

8. **Reward yourself!** It is crucial that you recognize the hard work it takes to make changes in your life. You need to honour your efforts. A nice meal out, a new CD, a bubble bath or an hour at your favorite hobby are examples of rewards that you can provide for yourself.
9. **Keep slips in perspective.** If you do succumb to old patterns, make the most of this experience. While it is important to recognize the serious impact this can have on your recovery, it can be used as a valuable opportunity to evaluate where you may not have planned or acted carefully enough. You can use this experience to strengthen your recovery, if you choose to do so.

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Harm Reduction



What is Harm reduction?

Harm reduction is a public health philosophy that supports policies and practices aimed at addressing risky behaviour. This philosophy not only recognizes that it is ultimately impossible to keep people from engaging in certain behaviours, but also in fact values people's right to make choices for themselves. At the same time, however, the core principle of harm reduction is that it is beneficial to prevent and reduce the harm that can be associated with risky behaviour. To do this, we must ensure that individuals are fully informed of risks, provide the means to make safer choices, and prohibit behaviour that puts others at risk.

This is why people are urged to use condoms with new sexual partners, why we all wear seatbelts, and why there are crosswalks for crossing the street. We recognize that people are going to be having sex, driving in cars, and crossing streets. We cannot and do not want to *control* these behaviours. However, because we also recognize that they are po-

tentially quite risky, we have put some effort into reducing possible associated harm.

This works the same way for addiction. If we recognize that people are going to be using potentially addictive substances or engaging in addictive behaviour, then we can also choose to put some effort into preventing and reducing potential harm associated with these risky behaviours. Simply put, harm

reduction is the philosophical underpinning of an approach to addiction that makes the reduction of potential harm the highest priority. Policies and practices are developed and implemented in order to achieve this goal. Equally importantly, these policies and practices should be measured according to their actual impact in preventing and reducing harm. Success is not reflected primarily through a change in use rates but rather by the change in rates of death, disease, crime, and suffering.

Origins and development

Harm reduction was originally developed as a social policy perspective in response to the spread of AIDS among injection drug users. Many practices associated with harm reduction are specifically directed to reducing the potential harm associated with the spread of disease. These include needle exchange, supervised injection sites, bleach kits, methadone maintenance, provision of smokable drugs such as heroin-laced cigarettes – anything that reduces injection drug use or

Harm reduction...

- accepts that some level of addictive behaviour in society is inevitable
- establishes quality of individual and community life and not necessarily the cessation of drug use as the focus of interventions and policies
- chooses to work on reducing the harmful effects of substance use in a way that supports personal choice, individual strengths, and the motivation to change without imposing moral judgments
- examines potential harms associated with use and with existing policies and practices in order to set priorities for policy development and intervention at the level of individuals, families, communities, and society

Source: Kaiser Foundation



Photo Courtesy of Health Canada

makes it safer. Such programs also facilitate contact between drug users and service providers, making it easier to offer education, counselling, and access to treatment and other services, including health care. The idea that harm reduction can be applied to any addictive substance or behaviour has gained popularity in recent years.

The range of harms that we need to address extends well beyond concerns about drug use itself and the health of users. Policy makers are also concerned about the spread of disease to sex partners and children as well as about property crime, violent crime, drug driving, child abuse and neglect, drug-assisted sexual assault, gang warfare, prison overcrowding, massive spending, and police corruption. These problems are best addressed by shifting to a comprehensive harm reduction approach at the level of prevention, treatment, and social policy.

Agreement and Disagreement

Almost everyone agrees with the goal of preventing and reducing harm. In an ideal world, of course, there would be no harm and no addiction. Controversy arises as to how best to prevent and reduce harm in our world. Some focus on use itself as the main problem and believe that the number one priority should be to stop all problem use. Some see this as impossible in a free society. Others argue that the use itself may not be the real issue or the main cause of related harm. In fact, stopping use without addressing other issues may only lead to greater distress.

An important principle of harm reduction is that a single approach cannot fit the needs of all individuals or communities. It questions the idea that use *itself* is the problem, as well as the idea that our first priority must be to eliminate or manage use. Instead, the emphasis is on the larger array of problems associated with addiction, including those that

contribute to use in the first place, and those that result from use. The basic goal is to facilitate change that can prevent and reduce the overall harm.

Harm reduction has been embraced as a fundamental principle for addiction services in British Columbia and within Canada's Drug Strategy. Preventing and reducing harm should be the goal of all prevention and treatment interventions as well as of all social

policy decisions and enforcement activities. All policies and practices should be evaluated against this goal of reducing the harm experienced by all individuals and communities.

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Preventing Addictions

Prevention is a key component of any effective drug strategy. It needs to span the entire spectrum of addictions services, and also needs to be well integrated into the health and social service system. Prevention encompasses a wide range of goals: minimizing individual and community risk factors; preventing or delaying onset of use; ensuring that use does not spiral into addiction; limiting the negative health and social impacts; and slowing the spread of disease. There is great potential to reduce the economic costs and human suffering associated with problem substance use through effective policy and practices. Prevention is an essential component.

Dan Reist, President of the Kaiser Foundation says, "Prevention is a necessary element in the foundational principle on which addiction services is built: preventing and reducing the harm associated with problem substance use and addictive behaviours. This is an interactive process and depends on people engaging with information, and connecting with other people and with their broader community, in a way that changes their behaviour."

There is a broad spectrum of programs and activities that come under the umbrella of prevention of substance use problems. Different strategies are appropriate for different groups of people. There are many diverse aims and goals that fall under the category of prevention.

An important concept when thinking about substance use prevention is risk and protective factors. Protective factors are those that can help a person avoid having problems with substance use. Examples of protective factors include: having good decision-making skills; ability to cope with stress and other difficulties; having a stable home life and good relationships with one's family; and having high

self esteem. While all of us have some innate protective factors, they can also be developed or enhanced. Risk factors are factors whose presence puts someone at higher than average risk of developing problems related to substance use. Presence of risk factors does not mean that someone *will* develop substance use problems, but the more risk factors are present, the higher the *chances* that problems may occur. Examples of risk factors for substance use problems include: having difficulties in school; lacking positive coping skills; living in poverty; disrupted family background and low parental supervision; having a mental disorder; being a victim of abuse; and having had a stressful life-change (such as retirement or divorce).

All prevention programs aim to increase protective factors and minimize or manage risk factors. Universal prevention focuses on broad social messaging, with the aim of shifting social norms in protective ways, for example:

- preventing cigarette producers from advertising at sporting events;
- when a celebrity or respected public figure speaks out against practices such as drinking and driving;
- public awareness campaigns to reduce social acceptance of smoking;
- not allowing advertisements for alcoholic beverages to air on television before 9pm;
- encouraging parents to be involved with their children and build strong family relationships.

Targeted prevention aims at a group of people who are prone to certain risk factors. The broadest kind are generally targeted at youth, aiming to delay or prevent the first use of substances. Education is a crucial component of such programs, since young people will be better able to make good decisions if they

The Many Faces of Prevention

Prevention activities encompass any policy or practice that aims to prevent or reduce the harm associated with problem substance use by intervening before the particular problem emerges. These activities can include:

- public information campaigns on the dangers of second hand smoke
- educating recent retirees on appropriate use of alcohol and medications
- employment skills programs for recovering addicts
- education about safe injecting practices for injection drug users, to prevent the spread of disease
- providing accurate information on substances, their effects, and associated risks to parents of teenagers
- distribution of pamphlets in conjunction with the dispensing of anti-psychotic medications, to convey information about the effects, risks, and appropriate use

Source: Kaiser Foundation

have accurate information about the substances and associated risks. However education about substances and their effects is only one part of prevention. Equally important are programs that seek to enhance or develop protective factors and minimize risk factors. Examples of targeted prevention include:

- teaching young people coping skills and enhancing their decision making abilities;
- providing young people with reliable information about substances, their effects, and the associated risks;
- providing excursions and other activities for residents in a seniors' complex, to reduce isolation;
- conducting after-school activity programs in lower income neighbourhoods, to provide recreational options for children living in poverty.

There are also a range of indicated prevention interventions that are directed at people exhibiting specific risk factors. The programs develop or enhance protective factors, while also directly addressing relevant risk factors. Indicated prevention activities may include:

- providing counselling or other supports to victims of abuse to support them in coping with past trauma;
- outreach programs for recent retirees, including information on appropriate use of medications and alcohol;
- day programs for adolescents who have had disciplinary problems at school involving substance use (e.g. who have been caught smoking marijuana at school);
- educational pamphlets to accompany antidepressant medications, explaining proper use of the medications and advising moderate alcohol intake.

Prevention activities continue across the spectrum of addictions services. Early intervention programs that aim to identify use in its early stages are a form of prevention, since their aim is to prevent a substance use problem from spiralling into a full-blown addiction. All forms of intervention programs incorporate aspects of prevention, that aim to prevent the problems from getting any worse. For instance, an intensive treatment program aims not only to stop the person from using substances in inappropriate ways, but also aims to rebuild positive coping skills

Role of Parents

Studies have found that most kids consider their parents to be the most reliable source of information on drugs and alcohol, but many parents are hesitant about raising these subjects with their kids. Here are some examples of what parents can do to reduce the chances that their children will experience problems with substance use:

- Model responsible and moderate behaviours with medical and non-medical substances, e.g.:
 - never drink and drive, and only drink moderately when children are around
 - limit use of painkillers and other medications to when they are absolutely necessary
 - try to avoid smoking in front of children
 - do not ask children to handle cigarettes or hold an alcoholic drink for an adult
- Teach good coping mechanisms and decision making skills by example – e.g., if you've had a bad day at work, have a hot bath instead of a stiff drink
- Teach decision making skills by empowering your children to make certain decisions that affect them
- Set reasonable boundaries and have a discipline style that is firm and consistent, but not autocratic
- Provide your children with consistent encouragement and support to build self-esteem. This will make them more confident and secure, and they will be better equipped to deal with life's problems and make healthy choices
- Talk to your children about substances, and listen to their questions and concerns rather than lecturing
- Let your kids know that you are always available to talk to them if they have problems or concerns, or if they need advice on a difficult issue
- Inform yourself about substances and their effects, so that you will be able to communicate good information
- Don't be afraid to ask for help if you're facing a challenging parenting situation

Source: Kaiser Foundation



Photo Courtesy of Health Canada



Photo Courtesy of Health Canada

and other aspects of the person's life that can ensure the treatment program has a lasting impact on improving their lives, e.g. by providing employment skills training.

A crucial component of all prevention programs is high quality information that is accurate and balanced. If a child is taught to say "No" to drugs, with the message that drug use destroys people's lives and jeopardizes their future, this alone may not be an effective prevention message. Such messages, while true, do not present a balanced picture. The child may observe older siblings or friends experimenting with substances, yet not experiencing any adverse effects and still succeeding at school. This observation may cause them to discount their prevention education altogether.

A more balanced message may contain information about various substances and their effects, and realistic accounts of the risks involved. While it may be the case that the vast majority of homeless injection drug users smoked marijuana as their first use of illicit drugs, it would be inaccurate to communicate that smoking marijuana makes it likely that the user will end up as a homeless injection drug user, since that group is only a small proportion of all marijuana smokers. Realistic messages about substances, their effects, and associated risks, accompanied by pro-

grams to enhance decision making skills, are likely to have greater impact than unbalanced information.

There are resources available for parents looking to inform themselves about substance use issues, in order to be able to address their children's questions. Marsha Rosenbaum, a drug education expert and a mother, has a website with practical advice on drug education, including feedback from teenagers. This site is accessible at www.safety1st.org. In BC we have a provincial agency that produces fact sheets and other information, available at www.preventionsource.bc.ca.

When evaluating information relating to substance use, consider the following questions:

- Who is the source of the information?
- What is their aim or motivation in providing the information?
- On what basis are claims made?
- Can you see evidence that it is based on scientific studies that are conducted by respected authorities?
- In your opinion, does it present a balanced view?
- Does it claim to know everything, or does it acknowledge gaps in our understanding of certain issues?
- Is it respectful, encouraging people to think and make their own decisions?

Reliable, evidence based information forms the basis for any prevention activity. Informed people who have positive coping mechanisms and good decision making skills, and feel well-integrated and supported within their environments, are better able to make healthy choices. Prevention of substance use problems is about building resilient individuals that have the necessary skills to withstand life's ups and downs, have trusted loved ones that they can depend on in times of need, and knowledge about the risks involved in various behaviours.

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Achieving Positive Mental Health

When was the last time you asked someone at the gym what was ailing them? Chances are the person on the Stairmaster beside you is exercising to increase their physical well-being, not fight an illness. So why do so many people wait until they develop a mental illness before taking steps to improve their mental and emotional well-being?

Public perceptions are an important factor, notes the Canadian Mental Health Association (CMHA). Media images portray physical fitness as sexy, a worthy pursuit for people with self-discipline and high self-esteem. In contrast, learning to deal with emotions and improve one's mental health is viewed as an indication of weakness, something only a sick person needs to do.

These widely held views prevent people from achieving positive mental health and increasing their resistance to mental illness, according to the CMHA.

According to Canadian and American statistics, one in five people has a mental illness at any given time. Moreover, people with low self-esteem are up to three times more likely to experience depression than people with healthy self-esteem, according to a study by Statistics Canada. And men and women under constant stress are almost twice as likely to develop depression than their less-stressed counterparts, the study concludes.

These relationships start young: a Canadian study of high school students' coping strategies found that self-esteem was the prominent protective resource youth could use against daily negative life events and that

problem-solving coping strategies were instrumental in helping adolescents to avoid too much stress and depression.

These findings show the logic of prevention programs and ongoing activities aimed at maintaining positive mental health, says the CMHA. Examples include stress reduction programs, activities that help children build self-esteem and community events that are accessible to members of society who may feel isolated such as seniors or people with disabilities.

Skeptics may point to the cost of such programs, but investing in mental health could actually reduce the overall costs of health care, notes the CMHA. For instance, according to recent research:

- In 1999/2000, 1.5 million hospital days in Canada were due to mental illness and suicidal behaviour.
- People with mental illness, as a group, represent the most frequent category of billings by general practitioners.
- Mental illness-related hospital stays account for more than twice the number of bed days as cancer does; in BC, the average stay is 45 days and roughly 19,000 people require inpatient beds for mental illness.
- In 2001, there were just over 30,000 admissions to the BC addictions service system. Of these, 6,600 were aboriginal, and overall the proportion of men (59%) was higher than the proportion of women (41%).
- At last count, almost 607,000 British

Tips for Reducing Daily Stress

According to a recent CMHA survey, three-quarters of Canadians feel really stressed at least once a month. Below are suggestions to cope with this mental health hazard:

- learn to delegate tasks: e.g. rather than cleaning the whole house by yourself, have each family member clean one room
- practice saying "no": if you're not sure about something, say you need more time to think about it
- put "relaxation time" on your "To Do" list each day
- prioritize: learn to distinguish between what is truly urgent and what you think is important (e.g. if you need to see the doctor about a lump, don't worry about sending a birthday card on time)
- consider yourself successful if you accomplish half- to two-thirds of the activities you plan for each day
- try sleeping for an hour more than you think you need
- challenge any thoughts that put yourself down or dwell on negative outcomes (e.g. "That was stupid of me to forget," or "I'll never finish this project on time")
- keep reminding yourself to breathe: to activate your body's relaxation response, breathe through your nose and make your belly rise and fall with each breath
- experiment with various activities until you discover what is truly relaxing for you (e.g. hot baths, listening to music, gardening)
- Quit Smoking

Ten Steps to Mental Health

- 1 Build a healthy self-esteem.
- 2 Learn to manage stress effectively.
- 3 Acknowledge and express your emotions.
- 4 Make friends who count.
- 5 Develop positive family relationships.
- 6 Create a reasonable budget and live within your means.
- 7 Learn to enjoy nutritious foods and regular exercise.
- 8 Create strategies to cope with changes that affect you.
- 9 Get involved in your community.
- 10 Have a spirituality to call your own.

Columbians over the age of 15 made contact with the mental health system for a primary diagnosis of mental illness and around 97% of these clients received some form of community service either from a mental health centre or a physician.

- Mental illness represents one of the top categories of "frequent users" of emergency room services.

In order to reduce the impact of mental illness, Canadians need to learn what positive mental health is and how to achieve it, says the CMHA. Health professionals have a variety of definitions for mental and emotional well-being, but the consensus is that mental fitness is more than just the absence of illness. The two qualities that appear most often in definitions of well-being are resiliency — the ability to rebound from life's setbacks — and empowerment which means having a sense of control over one's life whether one lives in an institution or in the community.

An important aspect of resiliency is learning how to cope with different situations. It is especially valuable to model good coping skills for children, so that they are better equipped to meet life's demands without their mental health suffering. If you've had a tough day or are experiencing some extra stress, do something that will take your mind off your problems and allow you to relax: take a bath, get outdoors, do some yoga, or listen to your favourite music. Try to avoid using alcohol or medications to relax or take your mind off your problems. It is important to exercise moderation in using such substances. Modelling good coping skills, and moderate and appropriate use of substances is an effective way of communicating to young people and improving their resiliency.

The relationship between positive mental health and overall health has been explored in detail by Aaron Antonovsky who studied survivors of Nazi concentration camps. He

noticed that some of them were in remarkably good health and had coped relatively well with their horrific experiences. To explain this, he theorized that people with a healthy outlook on life are more able to cope successfully with trauma and stress. He defined a healthy outlook (or a sense of coherence) as the extent to which people feel that life is meaningful, manageable and comprehensible.

Since many people with mental illness find meaning in life and excel in many circumstances, they, too, can strive for and achieve positive mental health. One individual who has is Maurizio Baldini, a mental health advocate and former lawyer with schizophrenia. Baldini says he finds it rewarding to offer support to others. "I have a positive outlook on life and have been lucky enough to build a comfortable life for myself."

The idea that health extends beyond the physical person is not new in other parts of the world. Many cultures do not differentiate between mental illness and physical illness. For example, Asian and African cultures, which tend to view health issues more holistically, consider any illness as a sign that the person's overall being is out of balance. In fact, some African cultures treat the whole community when a person has an illness, believing that if the person is sick, the community is sick.

These ideas are gradually emerging in Western medicine as well, says the CMHA. The mental health community considers both the individual and his or her experiences within a larger context that includes the immediate family, the workplace and the broader ecological, social and economic environments.

But even if the big picture doesn't appeal to you, research shows that well-being is possible if you develop and maintain supportive relationships with family and friends. According to Dr. Ian Pike, a wellness consultant in BC:

Whether we smoke or exercise are important determinants of health, but whether we live longer, healthier and happier lives because we jog and eat right is questionable. We do know, however, that strong social supports, such as family and friends that we can count on, regardless of the situation, are the best predictors of longevity.

In the daily crush of stressors and worries, it seems we may be starting to get the point about balance and peace of mind even if we don't talk about it as positive mental health. In a 2001 phone survey, the overwhelming majority of Canadians (91%) said that it is very important to maintain mental health.



Do You Have Positive Mental Health?

People with positive mental health are:

- **authentic:** live in the here and now, respond to people and events in a genuine way
- **realistic:** know the difference between what they can and cannot change
- **in the driver's seat:** take steps to control what they can change and take responsibility for their actions and feelings
- **open to experience:** willing to experience both their internal and external realities accurately and fully even if it means dealing with grief, anger or frustration
- **capable of intimacy:** are able to give and receive love and share their feelings with others
- **accepting of others:** gauge people by their individual merits and not according to race, sex, age or economic background
- **balanced in their reactions:** able to lead as well as follow, judge as well as empathize
- **able to enjoy life:** take pleasure in family, community, work and leisure without expecting perfection
- **self-accepting:** feel good in their own skin, like themselves and have a sense of being worthwhile

Source: Dr. Ian Pike

feeling that they know a lot about meeting their needs for mental health, and they feel more knowledgeable than they did a decade ago.

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Stress

Stress: we all know what it can feel like. In 2000/01, about a quarter of British Columbians indicated that they had "quite a lot" of life stress; two-thirds had "some stress." It's an everyday part of life and part of what makes us human. But what exactly *is* stress, and what can we do about it?

Stress is a physiological response of the body to any demand being placed upon it at any given time. These demands can come from inside the body (feelings, perceptions, attitudes, beliefs) or from somewhere in the environment (exposure to heat/cold, noise, someone yelling at you). When you deem a situation to be threatening, your brain releases hormones and chemicals that send alarm signals throughout your body so that it can prepare to take action. This adrenaline-pumping response results in increased perspiration, rapid breathing, increased heart rate, muscle tension, and sensory alertness. It's this "fight or flight" stress response that enabled our human ancestors to survive when face to face with a sabre-toothed tiger. Unfortunately, most of our modern "dangers" like workloads or family conflict are not situations we can easily fight with our fists or run away from.

It's actually quite important for us to have some stress in our lives; in healthy doses, stress can make us feel challenged, motivated and energized. When people are routinely understressed, they feel bored, and this can lead to depression. However, if what is supposed to be a short-term bodily coping mechanism continues over a long period of time, the reaction does more harm than good and can compromise a person's physical and mental well-being. Furthermore, both men and women are equally likely to be stressed.

The consequences of stress on the body are wide-reaching. Signs of stress can include sleep problems, digestive upsets or ulcers, appetite and weight change, migraines, high blood pressure, lower sex drive, restlessness or fatigue, frequent colds, and muscle aches. In someone who is already vulnerable, stress can also be a trigger for most mental disorders, depression and anxiety being the most common.

If a person continues to be stressed for a long period of time, signs of this can often be seen in their lifestyle as well. For example, they may develop unhealthy coping strategies, like an increase in drug, alcohol or tobacco use; dependence on caffeine to get through the day; or preoccupation with food. They may also feel isolated from others, feel angry and irritable all the time, worry constantly, become apathetic or unenergetic, and develop depression. Stress



Photo Courtesy of Microsoft

can be serious; one in six Canadians admit there's been a time in their life when they've been under so much stress they've wanted to commit suicide.

Top 10 Sources of Workplace Stress

1. Too much or too little to do. The feeling of not contributing and lacking control.
2. Lack of two-way communication up and down.
3. Being unappreciated.
4. Inconsistent performance management processes. Employees get raises but no reviews, or get positive evaluation but are laid off afterward.
5. Career and job ambiguity. Things happen without the employee knowing why.
6. Unclear company direction and policies.
7. Mistrust. Vicious office politics disrupt positive behaviour.
8. Doubt. Employees are not sure what is happening, where things are headed.
9. Random interruptions.
10. The treadmill syndrome: Too much to do at once, requiring the 24-hour work day.

Source: Global Business and Economic Roundtable on Mental Health and Addiction



Photo Courtesy of Shutterstock

workload, deadlines, decision-making power, degree and clarity of responsibility, organizational climate, and communication methods are some other things to keep in mind when thinking about on-the-job stressors. The conflict many people feel balancing work and home life is another major contributor and has increased markedly over the past decade according to a study by the Canadian Policy Research Networks. The attitude of the organization to its employees, and the

Stress can come from both the good and the bad: getting married, moving, changing jobs, getting divorced, having a baby, or coping with the death of a loved one. Things that often cause a person to worry can be major stressors too. For instance, frequently worrying about how to pay the mortgage or the rent, or how to get through a long-term illness can be very stressful. The day-to-day hassles of living, like traffic jams, rude people, and frustrating office machines heighten the general atmosphere of stress.

A national Ipsos-Reid survey in 2002 found that four in ten British Columbians listed work and finances as their primary sources of stress. Although stress is a normal part of the workplace environment and can provide us with energy, motivation and challenges to make our jobs fulfilling, the danger of a chronically overstressed workplace is a very real one.

There are many factors that can contribute to workplace stress. A person's relationships with their supervisors, colleagues, and clients matter a lot in determining their comfort level within the organization. Physical workspace,

kinds of flexible supports it offers — or doesn't offer — can either ease stress, or increase it.

Because stress can be so dangerous and debilitating, it's important for us to learn how to deal effectively with it as it occurs, and ideally, prevent or reduce its occurrence in the first place.

Often, the first thing a person can do is to identify their problems. Once you know what produces stress for you, you can move towards thinking about your options, and finding active solutions that can reduce your stress level. Whether it's your workplace, career or educational path, relationships, finances, health, or home life, thinking about what you can do, what the consequences will be, and which path you want to decide on can be a difficult soul-searching process, but it is probably a better long-term way of reducing stress in your life. Sometimes, even small changes can have a lot of impact whether it's checking your work email only once a day or delegating meal preparation to different people in your household.

There are also things you can do in the short term to reduce your stress level. The point is

Tackling Burnout

The American Psychological Association (APA) defines burnout as "a state of physical, emotional, and mental exhaustion caused by unrealistically high aspirations and illusory and impossible goals." With the increasingly fast-paced and resource-strapped environment of workplaces today, the risk of employee burnout is increasing as well. Symptoms can include:

- **Physical signs** (e.g. fatigue, sleep problems, loss of sexual drive)
- **Emotional symptoms** (e.g. feeling helpless, hopeless, irritable, depressed)
- **Behavioural signs** (e.g. aggression, substance abuse, callousness)
- **Work-related signs** (e.g. absenteeism, mistakes, inefficiency, theft, being late often)
- **Interpersonal symptoms** (e.g. withdrawal from clients or co-workers, cynicism and inability to focus)

Here are some tips on recovering from burnout:

- Be realistic.
- Talk about your feelings.
- Make sure your goals and aspirations are your own, and not someone else's.
- Create balance.
- Seek the guidance of a professional.

Work/life conflict

The conflict between work and home life has increased over the past decade. The conflict shows up as:

- *increased workload and hours of work* – the average employee surveyed spent 42 hours a week in paid employment in 1991, 45 hours in 2001
- *more stress* – high stress on the job is twice as prevalent today as ten years ago
- *declining physical and mental health* – more visits to the doctor, more cases of depression
- *increased absenteeism* – employees experiencing high work/life conflict have absenteeism rates three times those of employees with low work/life conflict
- *lower job satisfaction* – 62% were highly satisfied with their jobs in 1991, compared to only 45% in 2001
- *lower commitment to employers* – 66% highly committed to their organization in 1991, only 50% in 2001

Source: Canadian Policy Research Networks

finding the healthy approach that works for you. For many people, talking about their problems with someone they trust is a good way to vent and release tension. Problems often sound more manageable when you speak them aloud and the listener may even be able to offer you a different perspective and possible solutions. Many workplaces also offer Employee Assistance Programs for employees and their families to access for short-term counselling with trained professionals.

Since we're usually unable to prevent, reduce or even predict all of our stressors, management of our physical and emotional stress response is a crucial skill. Exercise, prayer or other spiritual ritual, eating and sleeping well are all different ways to take care of yourself, gain perspective and help reduce stress. In a Western culture that's a slave to the clock and to being "productive" all the time, it can be difficult but liberating to say 'no' and take a break — whether it's a vacation, a lunch or walk break, or a babysitter watching the kids one night a week. Although twenty-first-century life can be daunting, equipping ourselves with a critical view to the sources of our stress, a positive attitude and healthy stress-relieving techniques that rejuvenate us may be the most useful skill to learn in our lifetimes.

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Becoming a Good Stress Manager: An Ongoing Process

1. **Aware** – Becoming aware of the signs of stress and of your feelings, thoughts and wants in any given situation.
2. **Inform** – Gaining an understanding about your own sources of stress and how these contribute to negative stress in your life.
3. **Assess** – Assessing and prioritizing which source of stress to address first helps to focus your efforts.
4. **Learn** – Strengthening the skills you already have and learning two or three new strategies will help you adapt to many stressful situations.
5. **Plan** – Developing a plan that has a series of very specific things you can do to reach your stress management goal will help you stay on track and measure your successes.
6. **Act** – Just do it! Try out your new ideas at least twice. Don't worry if at first you don't succeed. Try again! See what has changed. Experiment and be creative.

Source: Canadian Mental Health Association, Ottawa-Carleton

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Mental Disorders and Addictions in the Workplace

In today's competitive work environment, many employees are reluctant to admit to having difficulty handling stress in the workplace; even fewer are comfortable discussing their mental health or substance abuse histories with their employers.

Nevertheless, these issues have a much greater impact on the workplace than most people realize. Since one in five people in BC has or will develop a mental disorder, most offices and job sites have at least one person with a history of major depression, an eating disorder, schizophrenia, an anxiety disorder, addiction or some other mental health problem.

However, because of the stigma attached to mental illness and addictions, employees often blame themselves and remain silent when they become depressed or are unable to meet employers' rising expectations because of a mental health problem.

Michael Koo, 34, says he was devastated when his coworkers complained in a performance evaluation that he wasn't pulling his weight. But Koo says he didn't feel comfortable explaining that a major depression was the reason for his low productivity. "My thought was, 'I can't afford to let them know what was going on, 'cause I'll lose my work,'" he recalls, adding that stress leaves were associated with shame.

Signs an Employee may be Experiencing Depression:

- an increasing difficulty making decisions
- a decrease in productivity
- an inability to concentrate
- a decline in dependability
- an unusual increase in errors in work
- proneness to accidents
- frequent lateness and increased "sick" days
- an uncharacteristic lack of enthusiasm for work
- personality or behavioural changes that appear "out of character" for the person

Keep in mind that people with depression will try hard to mask their illness because of fear of being reprimanded, dismissed or stigmatized for feeling down.



Jane, a 30-year-old biologist, says she never discussed her clinical depression with her employer because she was afraid of losing respect. "People in the workplace want to be dealing with consistent and reliable colleagues," she says. "Being perceived as being vulnerable to depression limits how much people feel they can invest in you." Although she hid her depression, Jane says she lost all credibility with her company when her work began to suffer. "I would fall short on my commitments and was unable to justify my inability to produce according to expectations," she explains.

In some cases, the fear of losing one's job and the respect of one's colleagues is enough to prevent people from seeking treatment. Physicians, for example, often deny their own mental health needs because they fear the loss of their practice if the community discovers they are being treated for a mental illness, writes Dr. Michael Myers, a psychiatrist who specializes in working with doctors.

Hidden or not, untreated mental illness and job-related stress are having a huge im-

What Co-Workers Can Do to Help

If a co-worker shows signs of clinical depression:

- continue to show them respect
- help make the person aware of their value in the workplace and to their colleagues
- offer encouragement and pay genuine compliments
- remind yourself and your co-workers that 80% of people with depression can recover if they get help
- use the trust between you to encourage the person to speak to their health care professional or your employee assistance professional who can direct the person to appropriate treatment

work as the biggest contributor to "serious stress" in their lives; this is up 12% from the same survey conducted four years earlier.

Stress in the workplace is a major cause of clinical depression among adults in their prime working years, the people who drive Canada's economy. In a 1999 survey, 46% of workers reported moderate to high levels of stress arising from the attempt to balance their work and home lives. Those who reported high levels of stress missed an average of

7.2 days of work, whereas those who reported low stress only missed half as many days. Stress isn't just evident in those absent from the office, either. More than a quarter of Canadians work excessively long hours and consider themselves "workaholics"; they are twice as likely to be stressed and report poorer health than non-workaholics. As a result, disability claims for stress and depression are skyrocketing. For example, long-term disability costs in Canada have increased eight per cent and short-term absence costs have more than doubled from 1997 to 2000, according to Watson Wyatt, a firm that audits disability claims. They also found that direct and indirect costs of these

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Ways Employers Can Help Reduce Workplace Stress:

- learn what causes workplace stress
- provide positive feedback and engage in two-way communication with employees
- offer flexible hours for juggling family responsibilities
- provide employee assistance programs to help people get counseling on personal, financial or other problems
- provide or help with cost of stress control programs
- offer on-site fitness facilities and access to nutritious food
- create an environment that offers fresh air, proper lighting, regular work breaks, and reduced noise
- permit someone recovering from a mental illness to work fewer hours rather than totally disconnecting them from the workplace

absences account for an average 17% of payroll expenses. Among younger workers, mental disorders are now the predominant cause of disability and a leading cause among all workers, according to a recent federal government study. Nearly one in four workers receiving a federal public disability pension has a mental disorder.

Problem substance use also has a significant impact on organizational effectiveness. Only 4% of people with substance use problems are among the visible and highly marginalized populations such as those on Vancouver's downtown eastside. The rest are active in the community, and are often em-



Photo Courtesy of Metrolinx

ployed. However their substance use problems may reduce their efficiency at work, and cause them to take frequent sick leave. Additionally, drug and alcohol use and other addictive behaviours (such as gambling) are usually associated with other social, family, legal, and mental health problems, which also impact workplace performance.

Nevertheless, many employers and organizations are slow to recognize the impact of mental health and substance abuse problems on the workplace.

For example, even though mental illnesses cost Canadian workplaces an estimated \$11.8 billion in lost productivity, the Workers Compensation Board of BC (WCB) does not recognize psychological disabilities such as clinical depression, addictions and anxiety disorders as occupational diseases, nor does it list them in its schedules for determining awards.

Employers often expect workers to be immune to stress and are reluctant to hire people with known mental health problems. But having a mental illness doesn't necessarily prevent a person from contributing as a valuable employee. In fact, companies that accommodate a worker with a history of mental illness often benefit from that person's unique talents.

For example, people with bipolar disorder (manic depression) are often highly entrepreneurial, creative and skilled at accomplishing many tasks simultaneously. The flip side of this illness is severe depression. But once they receive proper treatment, 80 per cent of people with bipolar disorder can return to work and continue to function as highly ef-

Work-Life Balance: Today and a Decade Ago

- average employee surveyed spent 42 hours a week in paid employment in 1991, 45 hours in 2001
- high stress on the job is twice as prevalent today as 10 years ago
- rates of depressed mood increased across the board for both genders and professional or non-professional job categories
- employees experiencing high work-life conflict have absenteeism rates three times those of employees with low conflict
- 62% of survey participants were highly satisfied with their jobs in 1991, compared to only 45% in 2001
- 66% highly committed to their organization in 1991, only 50% in 2001
- The authors estimate absenteeism resulting from work-life conflict costs Canadian firms almost \$3 billion a year. Such conflict also results in extra visits to the doctor, adding \$425 million annually to the cost of health care, not to mention more hospital stays, more medical tests, more demands on other practitioners and more prescription drugs.

Source: Canadian Policy Research Networks

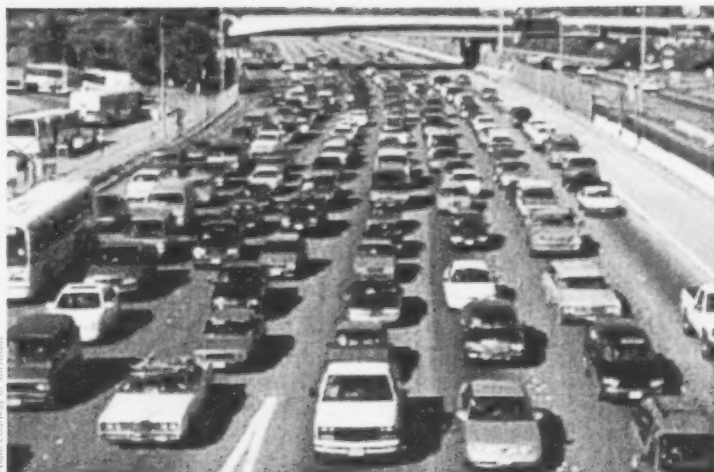
fective employees. Depression can also be successfully treated in more than 80% per cent of cases.

Workers with histories of mental illness or addictions are often better at pacing themselves than their highly-stressed counter-

Mental Illness and the Workers Compensation Board of BC (WCB)

- the WCB does not recognize psychological disabilities such as clinical depression, substance abuse and anxiety disorders as occupational diseases, nor does it list them in its schedules for determining awards
- long-term disability claims for psychological illness alone are extremely rare; such cases fall under non-scheduled awards, which are based on whether the disability is deemed to prevent the employee from returning to work
- most long-term disability claims for psychological illnesses are for post-traumatic stress disorder, which involves a sense of re-experiencing a traumatic event for months and sometimes years after the incident
- claims for post-traumatic stress disorder must be linked to a specific incident, for example, a police officer who has shot an individual during the course of duty and is unable to return to work because of ongoing emotional trauma
- claims for post-traumatic stress disorder have nearly doubled over the past decade: an average of 250 short-term and long-term disability claims for post traumatic stress were accepted each year between 1992 and 1996 versus an average of 485 such claims each year between 1997 and 2001.
- post traumatic stress disorder accounted for for less than 1% of the total number of accepted claims from 1997 to 2001
- accepted claims for post-traumatic stress disorder cost an average of about \$4.7 million per year, excluding health care and rehabilitation costs
- WCB: Toll free within BC 1-800-661-2112

Source: Statistical Services, Workers Compensation Board of BC



importance of maintaining an even keel to prevent a relapse.

Maurizio Baldini, a mental health advocate and former lawyer, says self-awareness, regular exercise and proper nutrition have contributed to his 13-year respite from schizophrenia. "Even the stress of a full-time job doesn't affect my mental health if I maintain a balanced life," Baldini says.

Although many organizations mention people as their biggest asset, few provide workplaces that support a balanced approach to mental health.

However, stress prevention is good business, according to Danielle Pratt, president of Workplace Health Promotion Inc., a Vancouver-based consulting firm. Companies that create supportive workplaces increase productivity and save on costs related to absenteeism, WCB costs and job turnover. Supportive workplaces can also improve employee relations and morale and allow workers to focus on the needs of clients, she adds.

Pratt mentions National Rubber as an example. In the early 1990s, the company was hit with a \$500,000 fine from the WCB because of its high accident rate. By adopting an attitude that all workplace injuries could be prevented and by involving employees closely in the process, the company was able to turn around a stressful workplace, disastrous safety record and a failing business. As a result, for two successive years, the company received \$300,000 back from the WCB.

Investing in strategies to reduce stress and support mental health needs in the workplace is a win-win situation for workers and employers — with or without an active mental illness.

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Seniors' Mental Health and Addictions Issues

In general, Canada's seniors are healthier, more independent and less likely to live in poverty today than they were 25 years ago, reports Health Canada. But that doesn't mean Canadians over the age of 65 are immune to mental illness.

Though many seniors have developed positive coping skills and emotional maturity, life experience is no defense against illnesses such as Alzheimer's disease, addictions, anxiety disorders and depression.

Major illness, retirement, the death of a spouse, a shrinking circle of friends — all may contribute to increased levels of stress and depression in Canada's elderly. In the over-65 age group, as many as 20% of seniors suffer mild to severe depression, ranging from five to ten per cent of seniors living in the community and 30 to 40% of seniors in long-term care facilities.

Depression is also hard to recognize and treat because it is often confused with aging itself. A key to correctly identifying and treating depression among seniors begins with education. Seniors, like many others, hold negative attitudes which stop them from seeking help. *Canadian Family Physician* reported in 1999 that seniors are among the most under-treated populations for mental health, estimating that mental health problems go undetected in more than one-third of the population aged 65 and over.

Seniors with depression are at particularly high risk for problems with alcohol. Older people who are depressed are three to four times more likely to have alcohol related prob-

lems than are older people who are not depressed. Factors such as retirement and isolation may put people at risk for developing problems with alcohol, especially if they are already accustomed to drinking. Use of medications, both prescribed and over the counter, is higher among older Canadians than younger Canadians. These carry potential risks from side effects, and inappropriate use or dependency.

Suicide among the elderly is another danger that often goes unnoticed. Elderly men are at a far greater risk of attempting suicide than women, with almost five times as many senior men committing suicide. Of all age groups in Canada, men over the age of 85 have the highest rate of completed suicides. Men over 70 are also hospitalized at higher rates than women for attempted suicide.

Deteriorating physical health can quickly change a happy retirement into a period of confusion, fear and chronic pain. When disabilities occur later in life, individuals who were involved in working, socializing and travelling may suddenly face lower incomes, reduced mobility and dependence on caregivers and assistive devices.

These changes can have a dramatic effect on seniors' mental and emotional well-being. And increased stressors also have consequences on physical health. Two recent studies in the journal *Psychosomatic Medicine* validate the link: one found that older adults who feel hopeless about the future are more than twice as likely to die over the next several years as those who are hopeful. Further

Reasons Depression May Go Unrecognized in Senior Citizens:

Seniors may:

- believe the myth that depression is just a natural part of the aging process
- see depression as a normal consequence of losing their independence
- already have other physical or mental illnesses (e.g. dementia or diabetes) and may not distinguish depression as a separate illness that can be treated
- experience depression as a side-effect of medications (e.g. such as some drugs for high blood pressure)
- feel embarrassed or ashamed to even discuss it
- be living with a constant, low-level form of depression known as *dysthymia* so may not even recognize it or think it can be treated
- not see any life events that could have brought the depression on and so feel it must be a personal flaw; or, alternately, have so many life events going on that could trigger a depressive episode that the person feels going to a doctor could serve no purpose
- come from a culture that holds different perceptions about what depression is
- lack the mobility or family support needed for a trip to the doctor
- believe treatment would be too long-term or expensive
- get depressive symptoms (e.g. problems with sleep or appetite) diagnosed as signs of a physical illness — or ignored entirely

Common Symptoms of Alzheimer's Disease and Related Dementia

- confusion or difficulty making decisions
- forgetting names of people and places
- having problems walking
- doing or saying things repeatedly
- having difficulty completing tasks like housework and grocery shopping
- acting restless or agitated
- sitting and doing nothing
- acting stubborn and uncooperative
- talking to one's self or talking nonsense

more, another study suggested that a positive outlook seems to protect older people against stroke.

As many as 20% of those 65 and older are caregivers for a loved one. Some elderly individuals may spend their days caring for a spouse with Alzheimer's disease or another form of dementia, such as Pick's disease, Lewy body dementia or primary progressive aphasia. Alzheimer's and related dementia can place a tremendous burden on caregivers since people with this disease eventually need help with bathing, getting dressed, using the toilet and even feeding themselves.

Though many seniors experience memory loss, dementia from Alzheimer's disease is not part of normal aging, says the Alzheimer Society of British Columbia. It is a progressive neurological disease that affects the brain and many of its functions including language, intellect and spatial orientation. Once the brain loses the capacity to regulate elementary body functions, people with Alzheimer's or related dementia die of malnutrition, dehydration, infection or heart failure. According to Health Canada, life expectancy for people with Alzheimer's is approximately eight years after the onset of symptoms, though some people have survived for more than 20 years after that.

In the end, caregivers pay the price too. In a 2000 study, older adults who were caregivers of loved ones with dementia had a much lower immune response to a pneumonia vaccine than their non-stressed, non-caregiver counterparts.

The loss of one's life partner is another major life stressor associated with aging. About a third of Canadian seniors are coping with the loss of their life partners, not to mention the gradual loss of their friends, relatives and social circles.

Though feelings of anxiety, grief and sorrow are normal reactions to major life changes, the most common medical approach to anxiety and depression in seniors is to prescribe drugs. According to Health Canada,

seniors make up 12% of the population, but they receive 40% of all prescription medication. At the same time, up to 50% of all prescriptions have been found to be taken improperly, reports the National Advisory Council on Aging which estimates that up to 20% of all hospital admissions are due to adverse reactions to medications or not following prescription drug instructions.

Some of the most widely-prescribed medications for seniors are known to be addictive and may cause numerous side-effects. For example, benzodiazepine medications — Ativan, Valium, Serax and Xanax, among others — are commonly prescribed for treating acute anxiety and insomnia. Although they are meant to be used for only a short time, benzodiazepines can be addictive and may cause side-effects ranging from fatigue, impaired performance and decreased ability to learn new things, says a report published in *Perspectives Magazine*. Nevertheless, 30% of senior women on Vancouver's North Shore are prescribed benzodiazepine medication to help them make it through the day or night.

Though medications are often helpful, elderly people may also benefit from information about alternative methods of dealing with emotional and stress-related illnesses, says Valerie Oglov, coordinator of the Older Women's Health Project based in West Van-

Tips for Maintaining Mental Health As You Age

- **maintain positive relationships with family and friends:** people with broad social networks enjoy better physical and mental health
- **maintain an adequate income throughout your life:** this reduces your risk of developing emotional illnesses, heart trouble and arthritis/rheumatism
- **seek opportunities to express your feelings** instead of trying to control your emotions
- **keep an open mind about life experiences:** this coping strategy helps counteract depression and the tendency to close in on yourself
- **pursue activities you enjoy,** particularly ones that put you in contact with others
- **try to make your own decisions** after gathering new information and the opinions of others
- **take risks and try new things,** without necessarily expecting to be successful immediately
- **do not be afraid to ask for help:** this is a sign of health and maturity and of taking charge of your life
- **reduce alcohol consumption**

couver. For example, seniors need opportunities to express feelings such as anxiety, frustration or grief and receive recognition from others that what they are feeling is normal and valid, Oglov says.

Communities can help foster seniors' well-being by providing the elderly with information on how to interact with the medical system, how to describe what they are experiencing and what questions to ask their physicians, she adds.

An increase in social and economic resources is needed to provide seniors with opportunities to cope and thrive successfully. For example, access to transportation and social activities are extremely important for seniors with physical disabilities, mental illness or both, who may otherwise be confined to their homes.

As Canada's elderly population continues to grow, staff in health care facilities, social services and community care programs must have geriatric training to help them understand seniors' unique needs.

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Children, Youth and Mental Disorders



Photo Courtesy of Health Canada

Reports from many jurisdictions indicate that the burden of suffering imposed by children's mental health problems and disorders is not diminishing. When present, they permeate every aspect of development and functioning, including family relationships, school performance and peer relationships. Often the most serious of these illnesses continue into adulthood and affect productivity and functioning in the community, particularly if they are not detected early and treated effectively. No other illnesses affect so many children in such a serious and widespread manner.

— Child and Youth Mental Health Plan, Ministry of Child and Family Development

Though Canada prides itself on its universal health care system, mental health services for children and youth are not keeping pace with the high rates of depression, suicide, eating disorders, schizophrenia and other mental illnesses in young Canadians.

A 2002 analysis of mental illness prevalence

studies concluded that 15% or around 150,000 children and youth in BC, "experience mental disorders causing significant distress and impairing their functioning at home, at school, with peers, or in the community" — anxiety, conduct, attention-deficit, and depressive disorders being the most common.

Depression and suicide are among

the most talked about youth mental health issues. In Statistics Canada's 2000/01 Community Health Survey, 32,000 or about 8% of young people in BC aged 12 to 19 disclosed symptoms consistent with major depression. About 20% of young people admit having considered suicide in the past year, and just under 10% having attempted it. Being bullied at school increases the suicide risk about threefold. That risk drops the more connected the youth is to their school.

Despite the number of children with depression, eating disorders and other mental disorders, many of these illnesses are left untreated in children, according to mental health advocates. For example, while an estimated 15% of BC's children and youth are needing help and would benefit from treatment, only 1%, or around eleven thousand children and youth, were connected to the mental health system in BC in 2002, according to the Ministry of

Signs of Mental Illness in Children and Youth

- **changes in behaviour:** e.g. an active child becomes quiet and withdrawn or a good student suddenly starts getting poor grades
- **changes in feelings:** for example, a child may show signs of feeling unhappy, worried, guilty, angry, fearful, hopeless or rejected
- **physical symptoms:** frequent headaches, stomach or back aches, problems eating or sleeping, or a general lack of energy
- **changes in thoughts:** for example, a child may begin saying things that indicate low self-esteem, self-blame or thoughts about suicide
- **abuse of alcohol and/or drugs**
- **difficulty coping** with regular activities and everyday problems
- **consistent violations of the rights of others:** e.g. thefts and vandalism
- **intense fear of becoming fat** with no relationship to the child's actual body weight
- **odd or repetitive movements** beyond regular playing such as spinning, hand-flapping or head banging
- **unusual ways of speaking** or private language that no one else can understand

What Parents Can Do to Help

- encourage your child to discuss his or her concerns, but avoid a confrontational approach; listen carefully to what he or she has to say
- check with your family doctor to determine whether there is a physical cause (e.g. iron deficiency) for your child's feelings of fatigue and low moods
- ask school teachers if they have noticed changes in the child or can suggest reasons for the child's altered behaviour
- ask if your school board has a staff counselor who can refer you to individual or group counseling to help children and teens cope with stress
- based on referrals from your family doctor or school counselor, book an appointment with a children's mental health team, psychiatrist or psychologist who works with children
- consider family counseling or a family support group to ease conflicts and teach family members how to support each other through difficult times

Child and Family Development.

One reason for the lack of diagnosis and treatment is that people do not expect mental illness to affect someone so young. Another is that identifying mental illness in children can be challenging, partly because young people change so much as they grow.

Parents may have difficulty distinguishing between normal phases in development and an underlying mental illness. For example, frequent outbursts of anger or tears may result from hormonal changes in puberty or they may be symptoms of depression, a drug and/or alcohol addiction or an eating disorder.

The pressures of school and growing up can be very difficult for some children to cope with successfully. Parents who look at situations through adult eyes may not realize the depth

of their children's concerns — and even if they do, other factors such as culture and gender, moderate whether a young person would even talk to their parents in the first place. In one BC study, Chinese youth, for instance, were twice as reluctant to consider parents a preferred source of help for depression problems (17%) compared to non-Chinese youth (33%). In both cases, girls were the ones more likely to choose friends over parents.

Proper diagnosis and treatment are critical to recovery since the symptoms of mental disorders can worsen over time. Without help, mental illness can slow a child's mental and emotional development and lead to problems in school, family upheaval, substance use problems and even suicide.

Children with anxiety problems or disorders — at least five percent of whom having significant problems such as panic disorder, generalized anxiety, obsessive-compulsive or post-traumatic stress disorder, social phobia, or other phobias or disabling fears — can have varying reactions and social consequences from upset and worry to anger, uncooperative behaviour and even aggression. Left unmanaged, anxiety in young people can worsen and lead to development of other problems such as depression.

Young people with depression are much more likely than other children to have low-self-esteem, problems in school, physical ailments and substance use disorders.

Conduct and attention deficit disorders, which may include hyperactivity, reduce a child's ability to direct and control his or her attention. Left untreated, these illnesses can interfere with the learning process and make it difficult for a child to live in harmony with family and friends.

Psychosis is a serious condition that often strikes young people, and often goes undetected for months and even years. It's characterized by symptoms such as hallucinations,

Mental Health and Mental Disorders among Canadian Children

Disorder	Prevalence (%)	Approximate Number in BC
Any anxiety disorder	6.5	60,900
Conduct disorder	3.3	30,900
Attention-deficit/hyperactivity disorder	3.3	30,900
Any depressive disorder	2.1	19,700
Substance Abuse	0.8	7,500
Pervasive development disorder	0.3	2,800
Obsessive-compulsive disorder	0.2	1,900
Schizophrenia	0.1	900
Tourette's Disorder	0.1	900
Any eating disorder	0.1	900
Bipolar disorder	<0.1	<900
Any disorder	15	140,500

1. The approximate number who may be affected is based on a population of 936,500 children and youth in BC (MCFD, 2002)

Source: Mental Health Evaluation and Community Consultation Unit

Resources for Children with Mental Illness

A comprehensive evaluation and treatment team may include:

- parents and family
- child or adolescent psychiatrist
- pediatricians and specialized physicians (e.g. neurologists)
- psychologists
- clinical social worker
- therapists/counsellors
- specific learning programs
- specific social skill and behaviour programs
- special schools or hospitals
- respite care services for the caregiver and family
- self-help groups and family support groups

delusions, paranoia, social withdrawal and at its most extreme, loss of contact with reality. The symptoms of psychosis may be related to ongoing illnesses such as schizophrenia, schizoaffective disorder, and some forms of unipolar or bipolar affective disorder (also known as depression and manic depression). Since early detection of psychosis is associated with a better chance of recovery, it's important to intervene as soon as possible.

Like adults, young people develop mental illness for a variety of reasons. Some children develop depression in response to major life changes such as moving to a new city, being bullied or going through their parents' divorce. Eating disorders such as anorexia or bulimia nervosa may be linked to depression, social pressures, low self-esteem and disordered food behaviours in the home. Children who are neglected, sexually abused, and/or exposed to family violence are much more vulnerable to mental illness. Genetic factors may also play a role. For example, research suggests that a child has an increased chance of developing schizophrenia if a parent, both parents or an identical twin is diagnosed with the illness.

Regardless of the cause, mental illness can make life difficult for children and youth and others around them. An adolescent with depression may feel worthless and believe that he or she is disliked by everyone. Children with attention deficit disorders may create havoc in the classroom and at home because of their impulsivity and difficulty expressing their true needs. And major illnesses, such as schizophrenia, may require extensive, ongoing care from parents which can lead to jealousy and resentments in other family members.

Nevertheless, professional and community support services that do exist throughout BC

can help improve the quality of life for the child with a mental disorder, the caregiver and the rest of the family. Many services offer practical support, education on mental illness, and messages of hope and recovery. The symptoms of mental illness are highly treatable and recovery is possible with the appropriate therapies, medications and support.

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Youth and Substance Use

Most teens experiment with tobacco, alcohol, or other drugs before they graduate from high school. Fortunately, the vast majority of drug use (with the possible exception of nicotine) does not lead to addiction, and most teens will not be significantly damaged by their experimental use. However, some will fall into abusive patterns or put themselves and others in danger.

In order to address the dangers effectively, we need to stop perpetuating some of the myths, provide honest information, and support youth in making responsible decisions. We also need to understand why youth use drugs and what factors might predispose them to, or protect them from, problem use.

Why Teens Take Drugs

Teenagers take drugs for many different reasons. For some people, alcohol and other drug use is a common and acceptable part of everyday life, even though it has certain risks. Adolescence is a time when teens are curious and willing to

take risks. They might start taking a drug simply as an experiment, to defy authority or provoke adults, to imitate adults, relieve boredom, or overcome shyness. They might take a drug to lose weight or appear cool.

Most problem drug use by teens does not result from accidental or experimental exposure to drugs. Teens who use drugs regularly do so for the same reasons adults do. Problem substance use is usually part of a much larger problem, like not fitting in at school, problems at home, not meeting expectations, personal stress, or trauma. Substance use may seem to help deal with these stresses or provide escape from dealing with them. Then the young person may come to feel that they need the substance to relax or get through the situation.

Preventing Problem Substance Use

One of the most important things we can do to prevent problem substance use by teens is to provide honest, evidence based information. Scare tactics do not work and are often counterproductive. Confronted with misinformation, teenagers will completely ignore our warnings and be exposed to real danger. On the other hand, studies indicate that students who quit using drugs often did so because of concerns about health and their own negative experiences. Effective prevention programs respect teens' ability to understand, analyze, and evaluate their options.

Problem substance use is strongly associated with adverse childhood experiences such as physical, emotional, or sexual abuse, growing

up with a parent who was chronically depressed, mentally ill, suicidal, in prison, addicted, or absent (experientially lost to the child), or in a context where the mother was treated violently. Other determinants of health such as employment, income, and social supports influence healthy development. Effective prevention strategies should address these determinants of health. Ensuring that children grow up in healthy environments is probably the most effective way of preventing problem substance use.

Connectedness and resilience are key protective factors. Connectedness refers to a sense of belonging, having strong and meaningful relationships with family, peers, and mentors.

Resilience refers to the quality that makes a person capable of dealing with problems and responding well to a range of life events. Just one caring adult can make a huge difference. Even when a child is facing adverse experiences, having one person who cares can assist that child

to overcome the challenges. The importance of involved, supportive parents cannot be over emphasized. Studies show that teens do regard their parents as the most trusted, but under utilized, source of information.

When Problems Emerge

Some teens will develop unhealthy relationships with substances. This is a fact that we can't change, but what we can change is how such situations are handled. If you notice that a child or teenager is presenting with several risk factors, or appears to be engaged in problem use, you *can* do something to help. The most important things are not to ignore such situations, and to inform yourself as best you can.

Here are some tips for what to do if you suspect your child or a young person you care about is engaged in unhealthy substance use:

- Try not to panic or over-react – it's natural to be concerned, but yelling or becoming angry will not help;
- Don't feel guilty – you are not to blame,

Common Myths

- Myth #1:** Experimentation with drugs is not a common part of teenage culture;
- Myth #2:** Drug use is the same as drug abuse;
- Myth #3:** Marijuana is the gateway to drugs such as heroin and cocaine;
- Myth #4:** Exaggerating risks will deter young people from experimentation.

Source: M. Rosenbaum, Safety First

Some Reasons Why Teenagers Take Drugs

Emotional Factors

- Attempting To Increase Self Esteem
- Escape From Emotional Upset
- Reduce Anxiety
- Avoid Making Decisions
- Asserting Independence

Physical Reasons

- Attempting To Feel Relaxed
- Blocking Pain
- Reducing Sensations
- Getting A Buzz – New Sensations
- Increasing Energy

Intellectual Reasons

- Reducing boredom
- Attempting to understand self better
- Satisfying curiosity
- Wanting to see the world a new way

Social Reasons

- Gaining recognition of friends
- Being "one of the gang"
- Overcoming shyness
- Escaping loneliness
- Aiding communication

Environmental Reasons

- Popular acceptance of alcohol and other drug use
- Difficult family situation
- Pressure to mature early
- Role models

Source: Drug Programs Bureau, NSW Department of Health

and it's more constructive to focus on improving the current situation;

- Inform yourself, and know the facts about the substances and their effects;
- Try to find out the extent of the substance use – was it experimental, or is it likely to continue or worsen?
- Pick a good time to talk to the child, and be honest with them. Express your fears and uncertainties, show that you care, and don't lecture or be judgemental. This will make it easier for them to come to you if they are having problems, or need advice.

It is important to be honest, and admit when you don't have the answers. This will build trust. The issues are very complex and there are many conflicting messages around. If you inform yourself as best you can and communicate honestly, your kids will come to trust you and will be more likely to come to you when they have questions. This trust will be reinforced if you treat them with respect, by encouraging them to think about the issues and make some of their own decisions.

A comprehensive range of information related to problem substance use is available at the BC Addiction Information Centre at

www.addictioninfo.ca. Another useful resource is provided by Marsha Rosenbaum, a drug education expert and a mother, who has a website with practical advice on drug education and communication with teenagers, accessible at www.safety1st.org.

If it seems that the child or teen is experiencing problems with substance use beyond experimentation, it may be beneficial to seek further help. The Alcohol and Drug Referral Service provides information and referrals 24 hours a day, 7 days a week. Their number is toll free in BC: 1-800-663-1441, or in the Lower Mainland call 604-660-9382

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What Do Teens Think?

Students themselves are not often asked to evaluate prevention efforts. Listening to the opinions of young people is an important place to begin. Students are hungry for accurate information, but believe that current programs are not meeting their needs. Here's what some say:

"It's just a really unrealistic way of teaching kids how to deal with drugs. It shouldn't be 'just say no,' but 'think about it,' or something like that. Like, 'use your brain.'"

"I think they need to make a distinction between drug use and abuse; that people can use drugs and still lead a healthy, productive life. You know, your parents can come home and drink a glass of wine with their dinner. They're not alcoholics."

"I think honesty is the core of drug education and the only thing that's going to help people not use drugs. When they're not being bombarded with propaganda for or against drug use, then it's more likely that kids are going to make more informed decisions."

Source: M. Rosenbaum, Safety First

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Childhood Sexual Abuse: A Mental Health Issue

Miriam is a bright and creative woman in her early thirties who, until recently, had a busy social life and a well-paying job. Now unemployed and living in her parents' basement, Miriam is recovering from a bout of depression and suicidal thoughts that have haunted her at various times since she was sexually abused by an adult family friend at the age of 14.

Almost 20 years after her abuse, Miriam is finally getting the emotional support and treatment she needs to heal her emotional wounds. But she still doesn't feel safe connecting with her feelings of deep sadness, pain and rage. "I guess I'm actually really afraid of myself. I'm afraid I might hurt myself because I really want to hit things," she says, adding that she fears her rage will never end.

Chronic depression is a common response to childhood sexual abuse, says Dr. Patricia Fisher, who studies the relationship between mental illness and child trauma. She adds that people with a history of child sexual abuse are also more likely to develop anxiety disorders, problems with identity and post-traumatic stress disorder (a sense of re-experiencing a past trauma) among other symptoms. One study has found that 33 to 86% of adult survivors of child sexual abuse develop post-traumatic stress disorder. And the US Public Health Service Office on Women's Health reports that 50-75% of women in addiction treatment programs are survivors of sexual violence.

The Effects of Sexual Abuse

People with a history of sexual abuse are much more likely to experience:

- post-traumatic stress disorder
- anxiety disorders
- chronic depression
- substance use problems
- personality disorders
- suicidal tendencies
- psychotic symptoms (e.g. delusions and hallucinations)
- dissociative disorders
- hepatitis
- heart disease
- fractures
- diabetes
- obesity
- alcoholism
- problems at work

Source: National Institute of Mental Health, Kaiser Permanente

Rates of Childhood Sexual Abuse in Adults

- general population: at least one in five women and one in ten men
- women accessing outpatient mental health services at Riverview Hospital: 36% to 76%
- inpatients with schizophrenia at Riverview Hospital: 58% of women and 23% of men had been sexually abused before age 17

Source: *Child and Adult Trauma Histories in Women with Major Mental Illness* by Dr. Patricia Fisher

vors of sexual violence.

A study carried out in the Department of Preventative Medicine at Kaiser Permanente, in conjunction with the US Centre for Disease Control and Prevention, has made some startling findings about the relationship between adverse childhood experiences (such as sexual abuse) and adult health. Dr. Vincent Felitti observes that "adverse childhood experiences are both common and destructive. This combination makes them one of the most important, if not the most important, determinants of health and well-being."

Fisher's study of women with schizophrenia at Riverview Hospital, British Columbia's psychiatric facility, compared the experiences of inpatients with sexual abuse histories with those of inpatients who hadn't been abused as children.

"The women who had trauma histories on the whole were younger, their illnesses more severe, and they were more likely to have a history of eating disorders, problem drug and alcohol use, depression and suicidal behaviour," Fisher says. She adds that many of the survivors of child trauma went on to experience repeated physical and sexual abuse as adults. "These poor souls are being multiply assaulted in a sense," she says.

Can child sexual abuse cause mental illness? The relationship between mental illness and childhood trauma is too complex to draw such a conclusion, Fisher explains. But a survivor with a family history of mental illness may be more vulnerable to developing the illness and may be more likely to express mental illness much sooner, she says.

At age 14, Miriam never thought her summer-long experiences of abuse could affect her self-esteem or future relationships. "Four months later, I named it as abuse and told

What is Sexual Abuse?

Sexual abuse consists of any sexual incident of sexual contact between a child less than 14 years of age, or between someone under the age of 18 and a person who is in a position of authority.

Sexual abuse may include:

- exhibitionism by an adult
- an invitation to touch by an adult
- being fondled or molested by an adult
- being forced to watch sexual acts or viewing of pornographic videos
- being forced to pose for seductive or sexual photos
- oral rape, rape, sodomy and/or incest

Child sexual abuse can take place:

- within a family by a parent, step-parent, sibling or other relative
- outside the home by a friend, neighbour, child care giver, teacher or random molester

myself that I wasn't to blame... so I kind of thought that I didn't have to deal with it anymore."

She says her abuse rarely entered her mind until her feelings resurfaced as a powerful body memory during a sexual experience at age 29. "My whole body shook with pain. I didn't know why this was happening and the only thought in my head was him [her abuser]," Miriam recalls. "Sexual pleasure and everything surrounding that on a physical level is where you get the most triggers," she adds. Now when Miriam remembers her abuse, she gets "real dirty feelings, like spit-it-out, vile, sick-to-your-stomach feelings."

Body memories or flashbacks of the abuse are common symptoms of child sexual abuse, as are feelings of intense shame, distrust, a sense of powerlessness and feelings of isolation and alienation, Fisher says.

The psychological effects of sexual abuse

may appear immediately or may take years to surface since many survivors blot their traumatic experiences from their minds.

Because of the intensity of the trauma, some survivors may experience delusions, amnesia and strange behaviour. Such reactions are very similar to the symptoms of psychosis, which involves a loss of contact with reality. As a result, some abuse survivors may be misdiagnosed as having a form of schizophrenia when a diagnosis of post-traumatic stress disorder would be more appropriate for their treatment needs, according to a report published by the National Institute of Mental Health in the United States. Fisher agrees there is a risk of misdiagnosis, but adds that such cases are rare with precise and competent practitioners.

Without treatment and support, abuse survivors with moderate or severe mental illnesses are more likely to experience physical and sexual assaults as adults. Fisher's study concludes. Nevertheless, few of the survivors at Riverview had reported their abuse and even fewer received any assistance after disclosure. A 1999 study adds to this picture, finding that the overall population of people with severe mental illness are two and a half times more likely than the general population to be the victims of violent crimes such as attacks, rapes or muggings.

"We have a duty of care to address child sexual abuse experiences among adults," Fisher says. "We need to improve quality of life for that person in the here and now." Dr. Vincent Felitti notes that "Most physicians would far rather deal with traditional organic disease. Certainly, it is easier to do so, but that approach also leads to troubling treatment failure and to the frustration of expensive diagnostic quandaries where everything is ruled out but nothing is ruled in."

Treatment for Survivors of Child Sexual Abuse

Individual and group therapies can help survivors heal their childhood wounds and learn to create healthy sexual boundaries as adults. Successful treatments will address the following issues:

- **guilt:** survivors need to be told over and over again that "it's not your fault"; therapies can help them identify and seek alternatives to self-punishing thoughts and behaviours
- **feelings of being tainted:** survivors need to learn that "I am okay physically and in every other way, and not damaged goods"
- **low self-esteem:** survivors need a lot of love and encouragement in believing that they are okay and good, as well as recognition for achieving small goals
- **trust:** group therapies can help a survivor learn to give and take support and gradually trust again
- **boundaries and empowerment:** survivors can learn what healthy boundaries are and practice asserting themselves through peer support and role playing
- **opportunities to express feelings:** in order to protect themselves both during and after the abuse, many survivors have had to stuff intense anger inside of them so it doesn't show; survivors need support and encouragement to express these repressed feelings which can otherwise lead to physical sickness, clinical depression or suicide



Photo Courtesy of Health Canada

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Stigma and Discrimination around Mental Disorders and Addictions

About one in five British Columbians is living with some form of mental disorder or addiction, but fewer than a third will ever get treatment. This is not due to a lack of mental health resources or effective treatments, but too often because people fear being labelled according to age-old stereotypes of people with mental health problems.

Even clinical depression, which has arguably received the most media attention this past decade, is still thought of as "a state of mind that a person can snap out of" by almost one-third of Americans in a 2001 National Mental Health Association survey. Addiction, which is a chronic and disabling disorder, is also often thought of as a moral deficiency or lack of willpower, and there is the attitude that people can just decide to stop drinking or using drugs if they want to.

The reality of discrimination has a very direct and real effect on the course and treatment of a person's mental illness or substance abuse problem. According to a Canadian survey in the early 1990s, the stigma associated with these problems prevented nearly half of those sufferers from getting help; similar data from the US puts the number at close to two-thirds of people with diagnosable mental disorders including addiction. Prejudice and discrimination have also been shown to influence treatment behaviour, from attendance at self-help or therapy groups to compliance with medication. Psychiatric outpatient drop-out rates have been shown to reach 50%, in part because people don't want to be seen go-

Facts About Addiction

- addictions occur in people of diverse ages, education levels, socio-economic situations, and culture
- addiction is not caused by moral weakness, or lack of self-control or willpower
- no one knows what causes addiction, but there are many factors that increase a person's risk of experiencing problems with substance use: these include biological factors, family situation, school/peer group influences, other social factors, and what sort of tools a person has to cope with stress or other life difficulties
- many people with addictions can't "just stop" using drugs or drinking – they need treatment

recovering addicts need support from their families, friends, workplaces, and other community groups – such support can help with recovery and decrease the chances of a relapse

Facts About Mental Illness

- one in five Canadians has or will develop a mental disorder
- mental illnesses affect people of all ages, educational and income levels, and cultures
- mental illness affects a person's thinking, feeling, judgment and behaviour
- mental illness is not contagious
- although there are no cures for some forms of mental illnesses, treatments can reduce the symptoms and help people lead productive and fulfilling lives
- the onset of most mental illnesses occurs during adolescence and young adulthood.
- a complex interplay of genetic, biological, personality and environmental factors causes mental illnesses

people with mental illness need caring support: these illnesses can place enormous emotional and financial strains on the person with the illness *and* their family and friends

ing into or waiting in the psychiatric wing of a hospital. The same is true, to varying degrees, internationally. One Israeli study found that if a person does seek the help of their family doctor, more than 80% of patients who ended up being referred to a psychiatrist refused the referral because of the stigma of receiving psychiatric care.

Discriminatory attitudes can also affect people's access to treatment for substance use problems. Someone with a problem may be reluctant to seek help (even through "anonymous" support groups) for fear of society's reaction if they were found to have a substance use problem. Another example is if someone commits a petty theft to get money to buy drugs or alcohol: the criminal behaviour is usually the focus, when what the person really needs is treatment for their addiction.

There is also evidence to suggest that community attitudes and discriminatory behaviours toward mental disorders and addictions may help determine a person's degree and speed of recovery. For example, the World Health Organization has found that schizophrenia has a better prognosis, or outcome, in developing nations not because of better medical treatment but because of societal reaction and integration of the person into the community.

The shame and discrimination associated with mental illness is the legacy of an era when the mentally ill were locked away in insane asylums, sometimes for the rest of their lives. Because of a lack of effective treatments, people with mental

health needs were regarded as "mentally defective" and incurable.

Change began in the 1960s with the introduction of powerful antipsychotic medications and advances in psychotherapy. As treatments began to offer relief from the more severe symptoms of mental illness, patients were deinstitutionalized across the country and treated on an outpatient basis or in hospital for short periods.

And yet, a 2001 Canadian study of people with schizophrenia still found that social withdrawal had a 'great impact' on their lives while the hallucinatory and delusional symptoms of their illness — thanks to advances in therapy and medications — had the 'least impact' on their lives. As a society, we have done much to alleviate major clinical symptoms of mental illness, but little to alleviate the symptoms of societal discrimination.

The major ways people with mental illness or addiction cope with the effects of self-shame or stigma — by hiding it, by educating people individually, or by withdrawing from potentially stigmatizing social situations — are not only generally ineffective but can be emotionally costly because they affect interpersonal relationships furthering one's social isolation. They also increase fears and worries of being discovered, and maintain a person's negative self-image of themselves. One study calculated that around 90% of people with mental disorders withheld information about their condition for fear of negative reactions, 25% revealed their illness only to close family members, and 7% did not even tell their close family.

These findings apply to individuals across the societal spectrum. Physicians, for example, often deny their own mental health needs because they fear the loss of their practice if the community discovers they are being treated for a mental illness or a substance use problem, according to Dr. Michael Myers, a psychiatrist who specializes in working with doctors.

Jane, a 30-year-old biologist who didn't want to use her real name, says that before she sought

treatment for clinical depression, she often committed to projects that she could have done if she weren't experiencing mental illness.

"At the time I didn't want to label myself as being depressed," Jane says, adding that she did not reveal her illness to her employers because she feared they would view her as "apparently defective."

Many people do not want an official record that identifies them as having mental illness or an addiction. They fear others might find out, treat them differently and judge them based on these problems. Sadly, in many cases, they are right. Subtle and overt discrimination against mental disorders and addictions continues to be documented by social scientists in the arenas of employment, education, housing, parenting, criminal justice, immigration, and other areas of social and community life.

Jane says that during her illness, her friends and family offered little understanding or support when she was feeling fragile. "People's judgments were really hard for me to accept and take," she says.

The loss of friendships and socio-economic status can affect people's lives long after their symptoms are treated and they are able to resume their daily activities. "Friends and family see you as a depressed person or a potentially depressed person," Jane says.

Negative stereotypes of people with mental illness — that they are lazy, have nothing to contribute or cannot recover — fuel misconceptions about these disorders and perpetuate prejudice and discrimination.

A recent study conducted in Alberta for the World Psychiatric Association found that nearly half of those surveyed said they wouldn't share a room with a person with schizophrenia and three-quarters said they would be unable to marry such a person. Researchers attribute this to widely-held beliefs that people with schizophrenia and other severe mental illnesses lack intelligence and are violent and dangerous.

For some people who are recovering, this can lead to feelings of emptiness, alienation and rejection. The isolation and loneliness may even trigger a depression, substance abuse problems, or a relapse. This drives up the personal cost of mental illness, which is already too high. Prejudice and discrimination are based largely on ignorance, myth and intolerance. The best antidote to this is targeted, community-based education coupled with direct positive contact with individuals who have experience with mental illness.

The knowledge that people can recover from these illnesses and contribute to society can help dispel society's fears and misconceptions about them and encourage more people to open up their hearts to themselves and others who develop a mental disorder.

It's also time to start calling stigma what it is — prejudice and discrimination. *Stigma* implies there is something wrong with the person while

Myths About Mental Illness

The most frequently cited misunderstandings about people with mental illness are that they:

- are dangerous or violent (88%)
- lack intelligence or are developmentally handicapped/mentally disabled (40%)
- cannot be cured (36%)
- cannot function or hold a job; have nothing to contribute (32%)
- lack willpower, are weak or lazy (24%)
- are unpredictable, can't be trusted (20%)
- are to blame for their illness and should "shape up" (20%)
- are barbaric, "psycho," not like normal people (14%)
- are contagious (6%)

Source: Canadian Mental Health Association, Ontario Division

discrimination puts the focus where it belongs: on the individuals and institutions that practice it. Liz Sayce, a researcher from UK's Mind charity who has written extensively on the topic of social exclusion asks why the mental health movement should be any different from other human rights movements; it's not as if we talk about the "stigma of being black — no, we talk of racism." People with mental illness and addictions and their families have been blaming themselves for far too long. It's time to put that energy towards examining society's attitudes, structures and policies.

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Fighting Stereotypes and Developing an Open Mind

One of the best ways to fight stigma and develop an open mind towards people with mental illness is to get to know someone with mental health problems and discover that the illness is only one aspect of his or her life. Another way is to speak up when friends, family or the media use language that discriminates against people on the basis of mental health problems. Here are some common signs of prejudice:

- stereotyping people with mental illness (treating them as a group rather than as individuals)
- trivializing or belittling people with mental illness and/or the illness itself
- offending people with mental illness through insults
- patronizing people with mental illness by treating them as less worthy than other people
- reinforcing common myths about people with mental illness: for example, saying they are dangerous, weak, beyond hope, etc.
- labelling people by their diagnosis; the concept of the person as an individual is lost, and the illness is the only relevant characteristic when terms such as paranoid schizophrenic, manic depressive and bulimic are used
- using slang words such as "insane," "schizo" and "psycho," which are often used in news headlines to grab readers' attention
- sensationalizing or accentuating myths about mental illness: for example, a headline such as "Psychotic Bear Kills Camper" links wild animal behaviour with mental illness

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Cross Cultural Mental Health and Addictions Issues

Mental illness and addiction know no colour, affecting the one in five British Columbians who identify as a visible minority equally as much as the population at large. They are equal-opportunity disablers, affecting anyone, regardless of culture or ethnicity. But as our communities reflect increasing cultural diversity, few of BC's mental health and addiction services are able to adequately respond to this diversity, although some efforts to make services more responsive are underway, for example the Multicultural Mental Health Liaison and the Cross Cultural Psychiatry Outpatient programs, run by the Vancouver/Coastal Health Authority.

While there are a number of factors that make services less likely to respond — e.g. lack of awareness about the need, or uncertainty over how to proceed — increasing the "cultural competence" of our mental health and addictions services is a necessary step to improving the well-being of a significant and growing portion of the population.

Data from the 2001 census reveal that over one million citizens of BC's 4-million population are immigrants — 60% of whom are from a visible minority. Of the 40,000 immigrants who arrived in BC in 2001, more than 75% were from an Asian country.

Immigrant and refugee populations, in particular, often have greater needs for mental health services because of the physical, emotional and psychological stresses involved in migration, resettlement and adaptation to a new community and a new life. A study of the factors most closely influencing the mental health of Southeast Asian refugees, for example, found that trauma, current stress and perceived health were all related to high rates of depression, anxiety and post-traumatic stress disorder. Among them though, it was a high rate of current stress — the degree of stress created by adjustment-related tasks like learning a new language, finding a job, rebuilding social supports and redefining roles — that was the strongest overall predictor of poor mental health and of mental disorder.

This is not just true for Southeast Asian people or for refugees. A recent analysis found that the odds of mental health or emotional problems were elevated in all non-English Canadian immigrants, particularly non-English-speaking Asian, African or Hispanic immigrants.

Racism is a real factor in the daily lives of people of colour and has mental health consequences. According to behavioural health

researchers, racism contributes to increased psychiatric symptoms, particularly those of depression.

The stresses of daily living and discrimination increase vulnerability to mental disorders or emotional difficulties, but cultural attitudes themselves can work to delay the help-seeking process. Mental illness and addiction are generally talked about more openly in the West, leaving many non-Western cultures more prone to burying or denying such problems altogether or until they get severe. According to Stella Lee who works with the Chinese Outreach Education Program of the Canadian Mental Health Association (CMHA), "There's a fear of mental illness because of the stigma attached to it. The families tend to cover it up. They don't want to let other people know."

Indeed, there is evidence that ethnic minorities experience mental health stigma more harshly than those from the majority group. Though it's not fully understood why, a greater sense of group identity in Asian and African cultures seems to extend stigma to the extended family more than in the Western world. As a result of this family-shared shame, coupled with different cultural perceptions of causes and treatments for psychological problems, research confirms that some minority groups in Canada delay long-

Well-Being is Universal

The definition of mental health and well-being is culturally bound. However, an Australian refugee project found that there are many components of well-being which are similar despite the cultural, religious, gender, and socio-economic status of individuals. These include:

- feeling and being safe and secure
- having meaningful and trusting relationships
- having a sense of belonging to a social group
- having a sense of identity
- having basic needs of life met in terms of housing, food, clothing, water
- being in control of one's own life
- being independent
- feeling good about one's self
- having physical and psychological health needs attended to
- having traumatic experiences validated
- having a sense of optimism or hope for the future

Source: Multicultural Mental Health Australia

er in seeking any kind of treatment than Euro-Canadians. In one BC study, Chinese youth, for instance, were twice as reluctant to consider parents a preferred source of help for depression problems (17%) compared to non-Chinese youth (33%). In cases where a would-be client is reluctant to seek help, Stella Lee encourages others such as family members to approach the person's family doctor.

A major part of the problem is a lack of appropriate multilingual, culturally- and spiritually-sensitive mental health and addiction services and a lack of active marketing of all mental health and addiction services to non-English-speaking minority groups. For example, in an Australian survey, Asians who spoke a language other than English at home knew significantly less about services for acute mental illness than their Caucasian peers.

Racism within the mental health and addiction system can leave many who do seek out services struggling to integrate a medical diagnosis of mental illness or addiction with their different cultural, spiritual worldview and conceptions of health, illness and healing. For example, what may be a spiritual experience to a patient may be psychosis to a clinician unfamiliar with the person's cultural and spiritual views. In fact, it has been acknowledged in studies that mental health practitioners are generally more inaccurate in diagnosing persons whose race does not correspond with their own.

Cultural differences often make it difficult for doctors and patients to communicate with one another. For example, Ethiopian people might consider frank discussions of medical problems inappropriate and insensitive and would expect bad news from doctors to be relayed to them through friends. A Chinese person may report bodily symptoms in a doctor's office and only offer emotional information about sadness and hopelessness if directly asked. If a person does communicate about emotions, it may be expressed in terms of metaphors. For example, in Chinese society, talking about "fatigue" or "tiredness" is often an indication of despair. Many First Nations people — who face similar challenges to foreign-born cultural groups — may be reluctant to seek help from mainstream mental health and addiction services because of the history of the way the community has been treated by white institutions. These communication barriers restrict access to care for many people from different cultural backgrounds. Moreover, immigrants in rural areas may ignore their mental health needs because they are isolated from the few services available that

are aimed at their cultural groups.

Local mental health and addiction services in BC need to bridge the cultural gap and meet the needs of these much-neglected Canadians. Perhaps most importantly, a dialogue needs to be found around cross cultural mental health and addiction issues, particularly about how social networks need to be supports, rather than substitutes, for mental health services. When we move away from the misconception that "people look after their own," we can start to talk about the way such services are planned, formed, and delivered so that more ethnocultural groups in BC know that there are places they can go to for help.

This dialogue can also help us understand different cultural approaches to healing that promote recovery. For instance, the World

Contacts for Immigrant Mental Health Services

- Education Program, Chinese Outreach CMHA, Vancouver/Burnaby Branch.
Tel: (604) 872-4902
- Vancouver Community Mental Health Services
Multicultural Mental Health Liaison Program
Asian & Latin American Services
Tel: (604) 874-7626
- Chinese Crisis Line-Richmond
Tel: (604) 279-8882 (Mandarin)
(604) 278-8283 (Cantonese)
- Family Services of the North Shore
Tel: (604) 988-5281
- Immigrant Services Society of BC
Tel: (604) 684-2561
- Surrey Delta Immigrant Services Society
Tel: (604) 597-0205
- Mood Disorders Support Group-Vancouver
Tel: (604) 738-4025 (Cantonese)
- SUCCESS (United Chinese Community Enrichment Services Society)
Tel: (604) 684-1628
- SUCCESS Burnaby-Coquitlam Office
Tel: (604) 936-5900
- SUCCESS Vancouver Family and Youth Program (Richmond Alcohol and Drug Action Team)
Tel: (604) 408-7266
- Taiwanese Canadian Cultural Society
Tel: (604) 267-0908
- Surrey Delta Progressive Intercultural Community Services
Tel: (604) 596-7722
- Alcohol and Drug Referral Service
Tel: 1-800-663-1441 (toll free in BC)
Tel: (604)660-9382 (Lower Mainland)



Health Organization has found that schizophrenia has a better prognosis, or outcome, in developing nations not because of better medical treatment but because of community reaction and integration of the person into the community. Many Asian, African and Aboriginal philosophies and remedies also value balance and harmony, appreciating how spiritual, emotional, physical and social elements work together and help or hinder physical and mental health; this interaction between mind, body and environment is too-often lacking in traditional Western-based clinical settings. The more knowledge-sharing that can take place around mental health promotion among cultures, the better care for the person needing help.

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Unemployment and Mental Health and Addictions

Unemployment rates for British Columbia continue to yo-yo up and down, but they never disappear altogether. At any given time, tens of thousands of people in BC are without work. But even though unemployment is ongoing issue in our society, the shame associated with job loss and the tendency for people to blame themselves for their unemployment continue to increase the population's vulnerability to mental illness and addictions.

In terms of major life upheavals, the stress of unemployment ranks alongside that of a serious injury, going through a divorce or mourning the loss of a loved one. Like other losses, the most common reactions to job loss include shock, anger, frustration and denial that anything bad has happened. Over time, unemployed workers may begin to question their abilities, their friendships, their purpose in life and even their self-worth.

Some people eventually adjust to unemployment, others find new sources of income, and a handful of people work towards social change to address the roots of unemployment. They focus their energies on changing external factors such as government economic policies, the rapid pace of technological change or a corporate decision to relocate a plant in a region with lower wage standards.

Nevertheless, research shows that most Canadians respond to job loss by internalizing their anger and becoming depressed. In a study of unemployed people who had been working for several years prior, one researcher found that 90% of respondents blamed themselves for their job loss, even though they acknowledged the economic reasons for the layoffs. They blamed themselves for not trying hard enough, for lacking initiative, for choosing the wrong major in university or for not pursuing a university education at all.

Many people internalize their anger because it is easier to blame themselves for losing their jobs than to admit that the reasons for their unemployment are beyond their control. But too much emphasis on individual responsibility can be psychologically destructive. One researcher found that job seekers with high motivation to land a new job were more likely than those with low motivation to experience depression and a sense of failure when job after job proved out of reach.

The tendency for self-blame robs power from people at a time they need it most. A survey conducted by the Canadian Mental Health Association and the Canadian Psychiatric Association

found that low income, unpredictable income and lack of control over income were strongly related to depression, anxiety and stress.

A person doesn't have to have lost a job to see these mental health consequences. One study shows that underemployment or inadequate employment such as forced part-time or low-wage jobs found similar increases in depression as with job loss itself. Another 2001 study found that simply the *threat* of layoff increased sleep and eating problems, depression and alcohol consumption.

Jane, a 30-year-old biologist, says her nine-month period of unemployment triggered suicidal thoughts and put her in "a state of almost physical inertia."

"My economic situation definitely played a role and made me more vulnerable to depression," she recalls. Jane received treatment for her illness and eventually found work as a biology consultant. She says much of her recovery came after "going from a period of serious financial problems and having to worry about

Tips for Coping with Unemployment

- create a new daily schedule including a regular time for job search activities, exercise and social activities
- if you are eligible for unemployment or welfare benefits, claim them as soon as you possibly can
- recognize that most people are not at fault for losing their jobs
- if you decide that you really were responsible for losing your job, find out how to improve your skills or attitude from books at your local library or courses offered through a Human Resource Centre
- find out about sources of low-cost entertainment, recreation, food and clothing in your community to reduce expenses
- reach out to family and friends for caring and support
- consider joining a self-help group or community employment program to share your feelings about unemployment and learn new skills
- tell everyone you know exactly what kind of work you are looking for; remind yourself that many people get their jobs through "word of mouth"
- keep busy and stay active outside your home; isolating yourself at home will not get you a new job and can lead to additional mental and emotional stress
- reward yourself for your efforts

People Who are Unemployed Lose More than a Job

Other losses may include:

- loss of daily structures that provide a sense of coherence
- loss of camaraderie at work and sometimes in the community
- loss of income and access to opportunities offered through the workplace (e.g. networking with colleagues, promotions, transfers, etc.)
- loss of self-worth and sense of purpose
- loss of peace of mind and feeling of security
- loss of social status and/or identity and loss of status within the family

money all the time, to just being poor and knowing I can at least pay my bills."

Unemployment does not cause a mental disorder but it can amplify the symptoms of pre-existing illnesses or trigger mental health problems for someone already vulnerable to them. Unemployment can also put people at greater risk of experiencing problems with substance use. Social isolation combined with having extra free time and fewer or no job responsibilities may increase someone's vulnerability to problem substance use through a need to fill a gap in their life, or even to pass the time. It may also increase the risk of a person acting on thoughts of suicide.

Evidence from a study of suicide rates in the UK suggests that unemployment was associated with more than a doubling of the suicide rate among those studied, even when other potential explanations for the link were accounted for. High unemployment rates have also been linked to increased rates of domestic violence, sexual assault, homicide, property crimes, racial tensions and substance use problems.

Although unemployment affects people of all ages and socio-economic backgrounds, it hits those hardest who are already most vulnerable in society including single-parent families, people with disabilities, visible minorities and immigrant families. Studies also show that in small communities with a history of low employment, individuals are less likely to suffer discrimination, and more likely to find community supports to help them through a period of unemployment. In larger cities with a greater range of socio-economic circumstances, an unemployed person is more likely to feel shame and less likely to access either formal or informal community supports.

People with mental illness are especially vulnerable. Unemployment and underemployment rates for people with significant mental disorders hover between 80 and 90%. People with mental illness face additional barriers to employment

since these disorders often strike in early adulthood at a time when education and job skills are being developed. Few supports are available for people seeking to resume these activities: "a person discharged from a psychiatric hospital has a better chance of returning to the hospital than of returning to work," notes a paper by Anthony, Cohen and Danley.

Nevertheless, the ability to participate in the workforce is the single most important factor in making a successful transition to the community at large.

Maurizio Baldini, 44, says returning to the workforce is possible with access to the right encouragement and support. A former lawyer with schizophrenia, Baldini was unemployed for a year following his last period in hospital more than a decade ago. He says his strong work ethic drove him to find a job at a clubhouse providing support to people with mental illnesses. "I got minimum wage, so it was quite a letdown economically compared to working as a lawyer. But it did give me a boost to work," he recalls.

Baldini adds that the ability to work helped him regain his independence and sense of purpose in his life. Now employed as a mental health advocate, Baldini points to the need for flexibility and affirmative action in the workplace. "I think many people with mental illness, given some type of opportunity, could really benefit from employment," he says.

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Housing for People with Mental Disorders and Addictions

Housing makes a difference to our health. Decent, safe and affordable housing contributes to physical and mental well-being, while inadequate housing or homelessness does the opposite. Having a pre-existing mental illness or a substance use problem often restricts a person's options to access, afford and maintain the very kind of home that would help promote recovery.

Because of a lack of supported housing options once discharged from hospital or treatment centre, many people with mental disorders or addictions have only substandard boarding houses or dangerous hotels to go home to.

The Experience of People with Mental Disorders

One reason for this is the episodic nature of mental illness. People with mental health problems often lose their income during long periods of illness and repeat visits to the hospital. They may have trouble paying the rent and may eventually lose their furniture and all of their household contents, along with their address.

Some people in this situation may decide they are better off on the street, but without a fixed address, they may be cut off from a range of social services including health care. Without access to medications and support, the person's symptoms may worsen and force them back into hospital, often for a longer period than the previous visit.

A small number of people may go without treatment for the disorder until they are arrested, and depending on the circumstances, end up in BC's criminal justice system. Emergency rooms also repeatedly see and discharge frequent users, many of whom are mental health clients, with most recovery gains lost when the person is back on the street.

Known as the "revolving door syndrome," this cycle is perpetuated by the lack of affordable housing and emergency supports available for people with mental illness.

British Columbians who believe there are more people wandering the streets with mental illness today than there were ten years ago are probably right. Around one-third of the homeless population has or will develop a mental illness. For many, mental illness predisposed them to homelessness; for others, the hardships and conditions associated with homelessness trigger mental illness. Shelters have been trying to pick up the slack with

some success: there has been an 88% increase in specialized shelter capacity for people with mental disorders in BC since 1987.

BC has a waiting list for 2,600 supported independent living units, according to the province's Mental Health Plan. The same document names housing as the single highest priority for service for people with serious mental illness.

In recent years, health care reforms have resulted in the closure of long-stay psychiatric facilities in favour of a holistic, community-based model for recovery. Although mental health advocates support the shift towards community care, they say the money saved in hospital beds has not been re-invested in

Types of Housing for People With Mental Illness

Residential:

- **licensed community residences** provide 24-hour supervision with professional staffing available on a daily basis; staff supervise use of medications unless a resident applies for permission to take his or her own medications
- **supported living homes** offer support staff during daytime hours; residents take their own medications
- **family care homes** are privately owned and provide care and supervision to one or two individuals who wish to live in a family setting

Supported Housing:

- **group homes** provide subsidized rent; tenants share a home and the services of a community living support worker
- **supported apartment buildings** are built especially for people with mental illness; subsidized rent and daytime support are provided
- **satellite apartments** are leased in private market buildings; tenants have access to subsidized rent and outreach services
- **supportive hotels:** single rooms are leased and managed by non-profit societies; on-site staff support provides services to adults with mental illness

Emergency Accommodation:

- emergency facilities offer short-term accommodation for people with no other immediate housing options available to them
- length of stay is usually under 90 days

appropriate housing and treatment supports which would allow people with mental illness to successfully re-enter the community.

In January 1998, the provincial health minister announced a \$125 million reform of the province's mental health care system. The reform includes a seven-year plan to replace BC's main psychiatric institution, Riverview Hospital, with 660 tertiary mental health beds and approximately 270 specialized residential mental health beds in smaller facilities throughout British Columbia.

This initiative will bring services closer to home for many people with mental illness, allowing them to benefit from the support of friends and family. Still, the plan to expand community treatment services in outlying areas will only work if it receives adequate funding, offers flexible supports and provides a range of housing options for people with different needs, mental health advocates say.

In many cases, access to housing and support services depends on participation in a structured program within a specific neighbourhood. But certain options such as segregated group settings are not always effective

in helping people integrate successfully in the community. People with mental disorders most often prefer to live independently, with access to flexible supports. One survey of 89 people with mental illness living in Vancouver's Downtown Eastside concluded: "The housing most [people] would like to live in is a self-contained suite or apartment."

The success of alternative housing programs such as Semi-Independent Living Programs (SILP) offered throughout BC is proof that people with mental illness can live well on their own in the community. Through this program, people receive rent subsidies in addition to other services like individualized skills training. Run by various non-profit agencies in the province, the program helps people locate and secure permanent housing and provides ongoing flexible support such as access to 24-hour crisis and care services, peer support programs and assistance with household maintenance, meal planning and money management. Funded by the Ministry of Health Services and administered by BC Housing, the provincial SILP program currently provides rent supplements to around 1650 people in BC. The average rental assistance is approximately \$250 a month.

Part of the program's mandate is to help people retain their housing during periods of illness, and avoid being bounced from one residence to another when their mental health needs change. The cyclical nature of some mental illnesses should not deprive a person of a place to call home, which is an important aspect of recovery.

The Experience of People with Substance Use Problems

Many of the issues identified above also apply to persons with addictions and concurrent mental health and substance use problems. However there are some unique factors relative to housing in the field of addictions. Often housing options like supportive recovery or even crisis shelters require abstinence in order to accept clients. This requirement does not parallel the mental health system, since supported housing does not require that clients be free of the symptoms of their mental disorder. The result is that many addicted persons fail to qualify for entry into these facilities, and remain on the streets or in environments that are not conducive to addressing their substance use problems. This situation suggests the potential viability of "wet" or "damp" housing options, that provide a safe environment for stabilization to clients who are unable to maintain abstinence.

The need for transitional housing has frequently been recognized within the addic-

Housing Shortages for People with Mental Illness

In BC:

- resources are required to provide up to 2,600 supported independent living units
- 10% of emergency shelter clients suffer from both mental illness and substance misuse

In Greater Vancouver:

- 1,916 people were on waiting lists for supportive housing in March 1998; the figure climbed to 2,060 people in September 1998 — an increase of 7.5% in six months
- 120 people have been on waiting lists for supportive housing since December 1989 or earlier; most clients are on the list an average of four years
- Lookout and Triage, two shelters serving high-risk populations, had to turn people away 3,600 times in 1998/99; more than the number they were able to admit
- 53% of refusals to requests for emergency shelter were due to a lack of available beds
- about 33% of people waiting for residential facility placements are being treated in Riverview Hospital or acute care hospitals even though they are deemed ready for discharge

Source: Vancouver Community Mental Health Services

What Does Adequate Housing for People With Mental Illness Look Like?

- units that are clean (e.g. no cockroaches), quiet, safe and close to amenities and support services
- choice of housing arrangements according to an individual's wants and needs
- access to housing located in a variety of neighbourhoods
- affordable housing units and furnishings to accommodate the needs of people on fixed or low incomes
- access to flexible, 24-hour supports as needed and wanted
- options for maintaining the same housing arrangement regardless of changes in a person's mental health needs

tions service system, and is provided through emergency shelters and supportive recovery facilities. These solutions however are short-term. This creates challenges since people coming out of treatment or supportive recovery may be left with no place to live, a situation which can put their recovery in jeopardy. Stable housing also gives people an environment in which they are better able to deal with their substance use problems. A Vancouver study found that a group of homeless or formerly homeless people were almost all involved with drugs or alcohol, and that they were more likely to address their addiction

if they were housed.

When people are secure and happy in their living environment, their chances of maintaining their mental health increase dramatically.

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Photo Courtesy of Health Canada

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The Economic Costs of Mental Disorders and Addictions

The societal impact of mental disorders and addictions extends far beyond the costs of the mental health services people require.

Depression, eating disorders, schizophrenia and other mental illnesses, as well as substance abuse tax the mental, social and economic well-being of the person with the illness, their family and friends, the community and on society as a whole.

The use of alcohol, tobacco and other drugs is associated with a wide variety of adverse health, social and economic consequences. In fact, recent studies conducted in industrialized countries show that the aggregate social cost of these adverse consequences is enormous, ranging from 1% to 4% of gross domestic product (GDP). For Canada, that would mean somewhere between \$10-40 B. The total cost of problem substance use in BC in 1992 was estimated at \$2.3 billion or 2.61% of GDP. Alcohol accounted for 42% of this cost, tobacco contributed 48%, and the remaining 10% was the result of illicit drugs. The largest cost component according to all the studies was the cost of losses in productivity.

In Canada, one individual out of five will experience a mental disorder at any one time.

These disorders place a heavy burden on provincial and national health care systems. In fact, even at an international level, psychiatric disorders are growing faster than heart disease as a percentage of the global burden of disease, according to the World Health Organization.

In terms of hospital-related costs alone, mental disorders result in the second-highest number of days spent in hospital: 9 million hospital inpatient days in Canada, with a month and a half as the average length of stay. According to Health Canada, hospital care costs

for mental disorders in Canada totalled \$2.7 billion, one and a half times more than hospital care costs for cancer. BC's share of that total is \$343 million.

The figures climb even higher when one considers the costs relating to problem substance abuse and worker absenteeism, reduced productivity and the time lost away from work by family members or friends who care for others with mental illness. For example, Health Canada calculates that direct treatment costs for mental illness in Canada total \$6.4 billion whereas another \$8.1 billion are indirect costs due to lost productivity from short and long-term disability and early death. The Canadian Centre on Substance Abuse estimates the direct health care costs related to alcohol, tobacco & illicit drugs at \$4.1 billion and productivity losses at \$8.1 billion.

Unrecognized depression has a tremendous impact in the workplace since depression hits people hardest between the ages of 25 and 54, who make up 70 per cent of the Canadian workforce. Left untreated, mental illness can drive up the cost of insurance rates and disability claims as well. An estimated 108,000 British Columbians — five per cent of the workforce — are currently experiencing a clinical depression that could result in insurance disability claims.

Workers who do not seek help put themselves and others at risk and, needless to say, affect the bottom line. For the first time ever, according to a 1998 study by the Homewood Health Centre for Organizational Health and The Canadian Business and Economic Roundtable on Mental Health, mental or emotional problems at work have exceeded physical causes as the primary reason for worker

What Does Mental Illness Cost?

To Canadian workplaces?

- lost productivity due to short and long-term disability for mental health reasons and early death costs Canadian businesses and employees an estimated \$8 billion a year
- Mental or emotional problems at work now exceed physical causes as the primary reason for worker absenteeism

To taxpayers who fund hospital revenues?

- In 1999/2000, mental illness resulted in 9 million hospital inpatient days in Canada with the average length of stay being 45 days
- in 1999/2000, of the 20,400 discharges of patients from psychiatric wards in BC, a quarter were re-admitted within 90 days.
- in 1998, hospital care costs for mental disorders in Canada totalled \$2.7 billion, one and a half times more than hospital care costs for cancer.
- the average cost of hospitalization for suicide and attempted suicide is \$5,500 per admission and can range from \$3,000 to \$31,000 depending on the length of stay, type of hospital and whether the patient died in hospital. In 1997, suicide cost Canadian hospitals \$100 million
- the direct hospital costs for schizophrenia alone are estimated at more than \$2 billion a year
- 1 in 8 Canadians will be hospitalized because of a mental disorder in their lifetime
- 16% of health care expenditures can be attributed to psychiatric disorders, but less than 4% of health research funding is currently allocated to mental illness.
- direct and indirect costs of mental illness are tagged at \$14.4 billion

To society!

- neuropsychiatric disorders are growing faster than cardiovascular disease as a percentage of the global burden of disease
- While psychiatric conditions are responsible for little more than 1 % of deaths, they account for almost 11 % of the disease burden worldwide
- 20 % to 25 % of the total costs of schizophrenia and depression to society are direct treatment costs; the remaining 75 % to 80 % of costs arise from lost social and economic productivity
- in one study, \$16.4 million was spent in Canada on peer-reviewed research into mental illness — the equivalent of 3.7 % of all biomedical research in Canada during the same period
- Alcohol, tobacco, and illicit drugs account for 25 % of the burden of disease in British Columbia

absenteeism.

The numbers indicate that employees are not getting the help they need in dealing with mental illnesses at an early stage. Unrecognized and untreated mental illness can become more severe over the long term resulting in an even greater cost to employers and the provincial and federal economies. Nevertheless, this trend can be reversed with appropriate treatment and caring support. For example, employers can help reduce the financial and emotional costs of depression by playing a role in providing access to information and education programs for their employees. Co-workers and employers can help reduce the social and economic impact of mental disorders by eliminating the stigma attached since internalized shame and the threat of prejudice and discrimination discourage many people from seeking help.

Despite the enormous personal and economic costs of mental illness, Canada spends relatively little, just 4 %, on funding research into its causes and treatments. In the first study of its kind in the States comparing funding for different illnesses and the burden they impose on society, researchers found, on the whole, funding was not allocated proportionately based on years of life lost to disability (an impact-of-disease measure used by the World Health Organization called a disability-adjusted life year or DALY). Causes with more vocal advocates such as AIDS received over \$1100 per DALY compared to only \$17 per DALY for depression. Mental health advocates across the country are calling for increased awareness, education and targeted funding for mental illness. These illnesses should be as much a priority as physical illness. The financial burden — let alone the social and emotional cost of mental illness — is far too great to ignore.

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The Personal Costs of Mental Illness and Addictions



of their mental illness, or a relapse.

Housing problems are directly related to poverty, the shortage of affordable housing and discrimination — all of which are major concerns for people with major mental disorders.

For example, unemployment rates for people with severe mental disorders hover around 80 to 90%. As for income, a survey by the Canadian Mental Health Association and Canadian

By law, people with mental illness are entitled to the same benefits of citizenship as other Canadians. In practice, however, many people with mental illness or addictions are denied access to a broad range of opportunities in our society such as employment and adequate housing.

The personal costs of mental illness and addiction may include a job, a family, an education and the ability to participate in social activities and community events. But few community resources are available to support people who wish to reclaim these activities.

For 30 years now, as part of a process called "deinstitutionalization," the mental health system has been moving away from traditional institutions in favour of a community-based model. But unfortunately, according to Health Canada, follow-through has been inconsistent and inadequate and "the closing of hospital beds has seldom been offset by a corresponding strengthening of community resources."

Without appropriate income and community-support services, people with serious mental health or substance use problems can become trapped in a "revolving door syndrome." Once released from hospital or residential treatment, many people with mental illness or addictions are forced to resort to substandard housing because of a lack of money. There, their health deteriorates, resulting in return visits to the hospital or treatment centre and an increase in the symptoms

Psychiatric Association found that low income, unpredictable income and lack of control over income are strongly related to depression, anxiety and stress. The combined stress of poverty and living with a mental illness can increase a person's vulnerability to problem alcohol and drug use, resulting in even more challenges to recovery. As many as 50% of people with serious mental illness may also have an addiction. Nevertheless, many individuals with mild, moderate or major symptoms of mental illness recover without developing a substance use disorder.

But they, too, may face tremendous personal losses as a result of their illness.

Stigma, misconceptions and discrimination leave people with mental illness and substance use problems among the most devalued of all people with disabilities. A major US nationwide survey investigated the many faces of discrimination and found that almost 80% of people with mental illness had overheard people making hurtful or offensive comments, 70% had been treated as less competent, 60% reported being sometimes shunned and avoided, and more than a quarter said they had often been told to lower their expectations in life.

Maurizio Baldini, 44, is a mental health advocate and former lawyer with schizophrenia. After five years of practicing law, Baldini experienced his second acute episode of schizophrenia which involved a delusion that compelled him to light some candles in his

Personal Costs of Mental Illness

Without adequate community services, people with mental illness may lose access to:

- adequate housing
- employment
- proper nutrition
- a livable income
- their children
- community activities
- leisure opportunities

house. When a large portion of his house caught fire and burned, Baldini was charged with arson and sent to BC's Forensic Psychiatric Institute to await his trial.

Although he was acquitted, Baldini says he was overwhelmed by the prospect of undergoing a disciplinary hearing to reapply for his license to practice law. "At one point I attempted to do that," he says, but adds that he changed his mind when he discovered the amount of time and money involved. "It's like another trial, going through the whole process all over again, just to get my license."

Baldini says it was hard to let go of his law practice, but it was much harder to cope with losing custody of his son as a result of his period in hospital. "My ex-wife was so bitter that she denied me access to my son," he says, adding that the courts have stood by her for 13 years. "The really sad part is, with an illness like this, he has a ten per cent chance of developing it himself," he says. "I could have been there for him."

Despite his experiences, Baldini has created a fulfilling life for himself and considers himself lucky. But some people who have been in the mental health system for an extended period of time lack the basic self-confidence and social skills that would allow them to feel comfortable in a community setting. Because of this and because of shame, prejudice and discrimination, many people find it difficult to gain employment and develop and maintain rewarding relationships with friends and co-workers.

Mental illness can take its toll on relationships with family members as well. For example, children who are living with a parent with a mental disorder may be confused and upset with their parent's behaviour or a sibling may feel jealous of the amount of time and energy their parent is spending on a child with mental illness. In some cases, relatives begin to feel trapped and overburdened as they struggle to balance caregiving with their other responsibilities.

The effects of substance use on family members can be just as distressing. A parent's drinking or drug use can impede their ability to care for their child adequately. As the child grows up he or she may learn drinking or drug use as a coping mechanism, if this behaviour has been modelled by a parent. Also if a young person or an adult experiences problems with substance use, the effects on their parents are significant. They may suffer feelings of guilt, as well as extreme concern for the health and safety of their child.

Nevertheless, family and friends who understand the nature of their relative's illness

can greatly improve his or her chances of long-term recovery. The key is to seek help from family counselors, self-help groups and other services that offer education, respite services and emotional support for families dealing with mental illness. With outside help, the experience can even draw family members closer together, as they learn to foster hope and support each other through difficult times.

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Mental Disorders, Addictions, and the Question of Violence

"Mental health status makes at best a trivial contribution to the overall level of violence in society."

— US researcher Dr. John Monahan, professor of psychology and legal medicine at the University of Virginia.

Of all the misconceptions about people with mental illness — that they lack intelligence, have nothing to contribute or cannot recover — the most common misconception is that people with mental illness are violent or dangerous.

This widely-held belief is fueled by sensationalist news headlines such as "Psycho Killer" and "Madman with a Machete" and by highly-publicized cases involving violent behaviour including several police shootings of men with mental illness in the Lower Mainland.

Mental health issues rarely make headlines unless violence is involved since violence and crime drive the content of daily news. As a result, media reports tend to perpetuate misconceptions that people with mental health problems are an especially violent class of society, when current research suggests that the level of public fear of violence from people

with mental illness in the community is largely unwarranted.

In 1996, Health Canada published a critical review of more than 100 scientific articles relating to violence and mental illness and its lead researcher did a follow-up report in 1998. Both reports found that the strongest predictor of violence and criminal behaviour is *not* major mental illness, but past history of violence and criminality.

Furthermore, current studies indicate that alcohol and substance use far outweigh mental illness in contributing to violence in society. For example, citizens are much more likely to be assaulted by someone suffering from an addiction than a major mental disorder such as schizophrenia, notes Health Canada. The report concludes that it is unlikely that a member of the public would be at risk of violence from a person with a mental disorder who does not also have a substance use problem.

Although mental health advocates have traditionally maintained that people with mental illness are no more violent than the general population, research during the past decade suggests that there is a modest relationship between violent behaviour and certain sub-

Facts about Violence and Mental Illness

- people with major mental illness (schizophrenia, bipolar disorder and psychosis) have more reason to fear violence than the general population, since they are two and a half times more likely to be attacked, raped or mugged than other members of society. This most often occurs when the following factors are combined: residing in a city, having transient living conditions, using alcohol and drugs, and living in poverty
- the strongest predictor of violence and criminality is past history of violence and criminality, whether mental illness is present or not
- about three per cent of violent offenses could be attributed to mental illness and another seven per cent to probable substance use. That is to say, only one in ten crimes could be prevented if these disorders did not exist.
- alcohol and other drug use far outweigh mental illness alone (as opposed to concurrent mental illness and substance abuse) in contributing to violence in society. So do gender, age and social-economic predictors. Young men, for example commit more violent crime than any other demographic group.
- it is unlikely that a member of the public would be at risk of violence from a person with mental illness who does not also have a substance use problem
- there is also a relationship between violent behaviour and symptoms which cause the person to feel threatened, and/or involve the overriding of personal control (e.g. feeling that one's mind is being dominated by outside forces)
- as with other types of violence, family members, not the general public, are the most likely targets of violence from people formerly hospitalized for mental illness who are most at risk of committing violent acts (see above)
- research shows that as long as people with severe mental illnesses (those who have been in a state of psychosis) stay in a treatment that works for them and take the appropriate medications, they are no more dangerous than the general population
- people with mental illnesses are no more likely to be charged with a violent crime than those who do not have a mental illness

How to Deal with Aggressive Behaviour

Aggressive behaviour includes increased pacing, clenching fists, yelling, pounding fists, kicking walls, shouting challenging questions and insults.

If a person is showing aggression:

- take all threats seriously; if at any time you feel threatened, leave the situation to protect yourself
- avoid touching the person and allow as much physical space between you as possible
- do not stand between the person and an exit, but make sure you have access to an exit yourself
- respond to questions with short answers so the person does not feel ignored, but do not answer questions that challenge you (e.g. "You're too dumb to help")
- avoid raising your voice and don't talk too fast (people under stress don't trust people who talk fast)
- stay calm and avoid nervous behaviour (e.g. crossing your arms, pointing your finger, standing with hands on hips or in pockets, shuffling your feet or fidgeting, making quick abrupt movements)
- be prepared to call the police if necessary

groups of people with mental illness, namely, those who also have a substance use problem or who are experiencing certain kinds of psychotic symptoms.

Another predictor of violence for people with mental illness is a recent history of victimization and violence in the surrounding environment. These environments "affect behavior by influencing the experiences, people, and situations to which individuals are exposed and from which they learn," accord-

ing to Dr. Virginia Hiday, sociologist and research affiliate with the US Center for Mental Health Services and Criminal Justice Research.

A recent, landmark US study examining violence risk of people with mental illness in the community confirms findings from the Health Canada review. This MacArthur Community Violence Study found the following:

- people with a major mental disorder diagnosis and without an addiction diagnosis are involved in significantly less community violence than people with a co-occurring mental disorder and addiction diagnosis.
- the frequency of violence among people who have been discharged from a hospital and who do not have symptoms of addiction is about the same as the frequency of violence among other people living in their communities who do not have symptoms of addiction.
- the rate of violence is higher among people — discharged psychiatric patients or non-patients — who have symptoms of addiction. People who have been discharged from a psychiatric hospital are more likely than other people living in their communities to have symptoms of addiction.
- violence committed by people discharged from a hospital is very similar to violence committed by other people living in their communities in terms of type (i.e., hitting), target (i.e., family members), and location (i.e., at home).

But it is not as simple as just attributing all violence to addictions. Researchers point out that, more than substance use disorders alone or mental illness (particularly psychosis) alone, it is the co-occurrence of the two disorder types that seems to escalate the risk

for violence. People with co-occurring disorders are over four and half times more likely to commit a violent act in the past year than people with one or the other type of disorder. The reason behind this link is not yet fully understood.

Comparing alcohol and drug use, a recent report by the Canadian Centre for

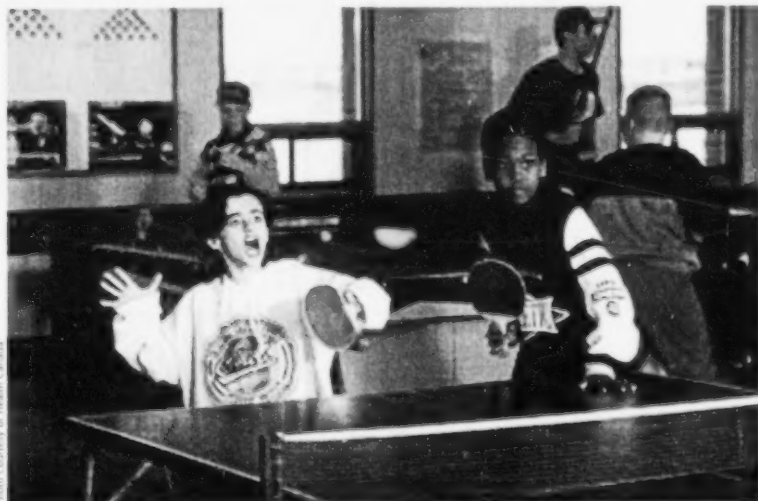


Photo Courtesy of Health Canada



Photo Courtesy of Health Canada

Health Canada reports that when violence is committed by people with mental disorders, it is usually limited to damage to furniture or minor assaults on relatives. The chances of being randomly attacked on the street are slim since family members, not the general public, are the most likely targets of violence. This fact isn't meant to sound alarm bells, rather, to remind us

Substance abuse suggests that drinking too much alcohol was the main contributing factor to one-third of murders and assaults studied. This number jumps another 20% when drugs are combined, but illegal drugs on their own contributed to less than one in every ten violent crimes.

The mental illness/violence equation is a complex one. In the end, as Julio Arboleda-Florez, the main author of the Health Canada review notes, it may be more productive for researchers to focus on studying a different question: "The most important question for the general population and for health planners interested in reducing the hazard of the risk of violence to the population may be, 'How much of the violence in the community can be attributed to mental illness?' not 'Does mental illness cause violence?'" he says. In 2001, Arboleda-Florez and his colleague tackled this question and calculated that about three per cent of violent offenses could be attributed to mental illness and another seven per cent to addictions; theoretically, only one in ten crimes could be prevented if these disorders did not exist.

Public perceptions of the relationship between violence and mental illness are important, since they determine how society defines mental disorder and controls access to mental health care. For example, almost half of the mental illnesses defined in the North American standard *Diagnostic and Statistical Manual for Mental Disorders* are defined in part on the basis of violent behaviour.

Public perceptions also determine how people with mental illness are treated by others at home, at work and in the community.

As psychiatric hospitals continue to downsize, the growing number of people with mental illness living in the community has raised concerns about public safety. However,

that any kind of violence is more common among people who are close to each other — this is true regardless of whether the violent person has a mental illness or not.

In some cases, mental disorders may even lower the potential for violence, according to Otto Wahl, author of *Media Madness: Public Images of Mental Illness*. The ability to carry out acts of assault requires a degree of mental coherence that may be difficult to achieve in some psychotic states, he writes.

Although many people fear violence from those who have a mental illness, research shows that people with these disorders are more likely to be victims of assault than to commit one.

For example, a national survey by the Canadian Mental Health Association found that people with mental illness are especially vulnerable to assaults, with most of them occurring in the home, in public places and in hospitals.

Since many people with mental illness experience lowered socio-economic status, they are often viewed as easy targets for mugging, rape and other assaults. In fact, a groundbreaking 1999 study found that people living with major mental illness (schizophrenia, bipolar disorder and psychosis) were two and a half times more likely to be attacked, raped or mugged than the general population. Anecdotal reports and complaints to professional associations suggest that individuals with mental illness may also face sexual assault from people they know including relatives, acquaintances and mental health care providers.

Like other people, individuals with mental illness can be victims or perpetrators of criminal acts and assault. Since violence affects everyone, it is a broader societal issue rather than specifically a mental health issue.

Whatever relationship exists between violence and mental illness, research suggests that violent behaviour in people with major mental illness can be prevented, treated and better dealt with when it does occur. Access to a range of treatment supports can help reduce the impact of violence, particularly in people with both a mental disorder and substance use disorder. For example, peer-based programs can help individuals learn more constructive ways to deal with and express feelings of anger, frustration and irritability.

As for violence against people with mental illness, prevention involves changing the power dynamics in families, institutions and in treatment settings. As long as people in authority are abusing those with little authority, individuals with mental disorders have greater cause to fear violence than has the general public.

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Coping with Mental Health Crises and Emergencies

For most people, getting treatment for mental illness involves booking an appointment with a physician, reaching out for support and perhaps taking medication. But in mental health crises or emergencies, help may be received under circumstances that are considerably more chaotic. Whether the situation is defined as a "crisis" or an "emergency," it is important that people with

mental illness can receive help in a way that is acceptable to them and that avoids, as much as possible, traumatizing an already-distressed individual.

BC's Emergency Mental Health Manual explains the relationship between these two terms, saying that a mental health *crisis* is "a serious disruption of the individual's baseline level of functioning, such that coping strategies are inadequate to restore (psychological) equilibrium. It is an emotionally significant event in which there may have been a turning point for better or worse." The Manual goes on to say that a crisis may or may not represent a psychiatric *emergency*, which "...impl(ies) danger of serious physical harm or life-threatening danger."

In other words, a crisis is a situation in which outside help is needed, and it may or may not involve a situation could be dangerous to the individual or those around him or her. When a mental health crisis exists, it is important to intervene before the situation evolves into a full-fledged emergency.

In a mental health crisis or emergency, the individual or his or her family should first contact community support networks such as the local mental health emergency team, mental health centre or family physician. Calling the police may also be an option after these other options have been tried, or if no other option is available, although it should be anticipated that the presence of police could intensify the fear and stress of the person experiencing a mental health emergency, qualitative research suggests. "Some people are dangerous, but a softer approach rather than strong-arm tactics would reduce the terrible amount of fear," said one participant in a series of community consultations held by the Canadian Mental Health Association.

In some parts of the province, however, police are specially trained to intervene, in collaboration with local mental health emergency services (e.g. Car 87), and are dressed in plain clothes, a strategy which can make police involvement less threatening for the person with mental illness and the family. Police are increasingly making use of non-violent forms of crisis intervention, and are making use of non-lethal tools such as TASER guns, in situations which have escalated to the point where non-violent crisis intervention is not possible. TASER guns require extensive training to employ effectively and should only be used after non-violent forms of intervention have been considered.

The criteria for involuntarily detaining a person — that is, against their will — for psychiatric assessment and commitment to an institution vary from province to province. In BC, most of the circumstances in which individual rights may be waived because of mental disorder are covered

How Families Can Help in a Mental Health Emergency

When an individual is at risk of self-harm or harm to others or is experiencing mental or physical deterioration, families should take the following steps:

- speak calmly to the person experiencing distress
- reassure the person that he or she doesn't have to face the crisis alone
- try to lessen the fear surrounding the experience of the illness and potential treatment
- call the local mental health emergency team, crisis line, mental health centre or family physician
- identify a person with whom your relative has a trusting relationship, and attempt to work through that person
- call the police as a last resort in life or death situations or if none of the other options are available to you

Families should be prepared to provide the following information to the police either by telephone or upon police arrival:

What has happened?

What is happening now?

- Identity and date of birth of the person who is experiencing distress?
- Is your relative being prescribed any medication? Has he/she been taking the medication? What is it?
- Has your relative been taking street drugs or alcohol?
- Does your relative have access to firearms or other weapons?
- Does the person have a previous history of attempted suicide or violence?
- Have the police been called to the residence before?
- Name of the family doctor and telephone number? Can he or she be reached for consultation?
- Does the person have a therapist? If so, can the therapist be contacted?
- Is your relative involved with the local mental health centre? If so, who is the contact person?

Mobile Crisis Assessment: Car 87

For the Vancouver Police Department, standard police procedure in community mental health assessment situations is to call Car 87, a special partnership unit comprised of a police officer and a mental health clinician (usually a psychiatric nurse or mental health worker) who use non-threatening measures towards the person in distress. In Vancouver, the car only operates outside normal business hours; daytime emergencies are handled by workers at one of the mental health teams. Car 87 answers about 1,000 calls a year.

in the provincial Mental Health Act (Bill 22) which was amended in November 1999.

Section 28 of the revised Mental Health Act gives police responsibility to take a person into custody who is "acting in a manner likely to endanger his or her own safety or that of others and is apparently suffering from mental disorder." The decision to detain someone can be made based on the officers' observations or information provided to them by other people.

The police may take the person immediately to a physician who determines whether the person is mentally disordered and meets the criteria of "dangerousness" (risk of self-harm or harm to others) or "deterioration" (a past pattern of mental and physical deterioration that leads to serious impairment).

On the certificate of the physician, the person may be taken to a psychiatric facility and detained for an assessment period of up to 48 hours; otherwise, if judged not to meet the criteria, the individual must be released. During the assessment period, another physician must complete a second certificate stating whether the person meets the "dangerousness" or "deterioration" criteria for admission to a psychiatric facility.

The Act states that once a person is admitted to a psychiatric facility, treatment authorized by the director is considered to be given with the consent of the patient. An amendment to the Act has added that a person admitted involuntarily (or someone on their behalf) has the right to request a second medical opinion on whether or not the treatment they are being given is suitable. In the end, it remains up to the director of the facility to determine if a person's treatment should be changed.

When considering how to respond to mental health crises or emergencies it must be remembered that comprehensive community mental health services — such as housing, case management, early intervention services, and crisis response systems/psychiatric emergency services — could help prevent psychiatric emergencies from developing in the first place.

As part of the Mental Health and Addictions Reform Initiative, BC is in the process of developing a comprehensive community mental health

system, including crisis response systems. The components of such a system should involve crisis lines, mobile crisis outreach (such as Car 87), walk-in crisis stabilization services, community residential crisis stabilization units, as well as hospital-based emergency services.

Community supports such as these, and access to quality services around the clock could act as the first line of defense against the suffering caused by relapse and untreated mental illness. The need for 24-hour crisis lines and community supports is especially acute in smaller communities; such services would go a long way in reducing the number of mental health crises, and the number of mental health emergencies that require hospitalization.

Mental health policies need to focus on building trust and rapport between people with mental health needs and service providers in the community. This would encourage individuals with acute symptoms of mental illness to seek help early on, thus reducing the risk of the problem developing into a mental health emergency.

Comprehensive approaches to community support also include peer-based support services, opportunities to participate in the workforce and policies that treat people with mental illness as valued and contributing members of society. Initial research suggests that people find these services more helpful than any other form of intervention.

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TASER Guns

The TASER gun is a device that propels tiny probes, attached to the gun by two cords. A high voltage, low wattage current runs through the cord, temporarily paralyzing the individual when the darts penetrate the skin or clothing. It is not a substitute for non-violent crisis intervention approaches, but can be a life-saving alternative to the use of "lethal force", in situations where there is an imminent threat, after other alternatives have been attempted. The use of the TASER is also limited to situations where the individual is not wearing bulky clothing (which would prevent the probes from being effective). In addition it cannot be used in situations which are beyond the range of the attachment cord (approximately 20 feet), and in extremely close-in situations, where the police officer may be in danger.

Some Rights of Individuals Admitted Involuntarily to a Psychiatric Hospital, and Rights of Families

- the right to be informed of the reasons for detention and of the available review process
- the right to a review panel with an advocate representing the individual
- the right to counsel from a lawyer in cases where the individual was committed under the Criminal Code of Canada
- the right to be fully informed of the rules and regulations and legal rights pertaining to the person's hospitalization
- the right to see his or her hospital record, to attach a statement of corrections and to have specific parts of the record copied, without charge, unless harmful to third parties or self
- the right to have all information relating to care while hospitalized shared only with individuals directly involved with treatment of the person, except where required under law
- the right, if eligible, to vote in any municipal, provincial or federal election
- the right not to be subjected to any form of cruel and unusual treatment or punishment
- the right of access to an independent organization to investigate any alleged violations of these rights
- for families, the right to be informed of the detention of their family member

Source: Riverview Hospital
Charter of Patient Rights

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Overdose: What to Do

An overdose occurs when a person consumes more drugs than their body can safely handle. These drugs could be illegal drugs such as heroin, or legally prescribed or over the counter medications.

Recognizing An Overdose

Depressants:

Moderate: uncontrollable nodding, inability to focus their eyes, excessive drooling, pale skin colour, incoherent speech.

Serious: Awake but unable to talk, persons body is very limp, erratic or very shallow breathing, excessive vomiting.

Severe: Unconscious, blue skin, person might not be breathing, can't find a pulse or it's shallow or erratic, choking or gurgling sounds, lying in their vomit.

Stimulants:

Moderate: incoherent speech, extreme paranoia, pale skin colour, jaw or teeth clenching, aggressiveness, minor shakes, excessive sweating, clammy skin, very rapid pulse.

Serious: inability to focus eyes, vomiting, foaming at the mouth, pressure or tightness of the chest, unable to talk, unable to walk, erratic pulse and violent actions.

Severe: seizures, unconsciousness, choking or gurgling sounds, not breathing, no pulse.

What To Do

- Call 911 immediately: tell them the facts and symptoms.
- Check that the person's airway is clear – if their fingertips, mouth, lips, or gums turn bluish or dark, they are not breathing sufficiently. Tilt their chin up and head back, straighten the airway, pinch their nose shut, form a tight seal of your mouth on theirs and give them two quick breaths every five seconds.
- Once the immediate crisis has passed, consider whether the overdose may have been a suicide attempt, or the result of a substance use problem. Intervening to address these issues may avert future crises.

Source: Kaiser Foundation

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Mental Disorders: What Families and Friends Can Do to Help

In the days when people with mental disorders were sent straight to psychiatric hospitals, contact with family was often limited to a brief visit here and there.

But with the shift towards a more balanced health care system, mental health care professionals are recognizing that support from friends and families is one of the best ways to help someone who is ill. Families can be members of the treatment team, where family is defined as an extended network of parents, children, siblings, spousal partner, and other relatives and close friends.

Since early intervention is the best treatment, family members can help by recognizing early warning signs of mental illness, which can include changes in eating and sleeping, increased hostility or suspicion, apathy, withdrawal from others, major changes in personality, nervousness and problem substance use.

Family members should seek the help of a professional caregiver if a relative shows any of these symptoms. But after taking this step, friends and relatives should focus on treating the family member with love, respect and compassion, says Miriam, 31, who is recovering from clinical depression.

"The most important thing [families] have to do is accept you completely, with all your faults," she says, adding that families can help by saying "You're okay, we love you, and you'll get better."

Families should remember to be patient. "As soon as you start looking better and acting better, they assume that you are better. They don't sympathize with the ups and downs of recovery," she says. Miriam also mentions the need for financial support. "For most people, when they crash, they can't look after themselves financially."

Families can help with medication by seeing that the prescription is filled regularly, reminding the person to take his or her medication and by alerting the professional caregiver if the family member shows signs of having stopped taking the medication. Family observations can also help the physician find the right medication and right dosage, usually a matter of trial and error. Families also help with emotional support, problem-solving, financial and housing support.

Relatives can help a family member with schizophrenia by negotiating with the person

What Families Can Do to Help

- encourage the person to get some help from a doctor or trained professional — early intervention is the best treatment if hospitalization is required, try to get your relative to go voluntarily
- try to be as supportive, understanding and patient as possible
- express your love for the person with affectionate words and warm hugs (unless the person does not want to be touched)
- consider joining a parent/spouse or other family support group to work through your own emotions and get help from others
- avoid blaming the person for his or her illness

and the treating physician to hold family education programs. According to a recent review, family education can reduce the rate of relapse and rehospitalization by up to 50% in the first two years after release. These strategies have shown similar benefits for a range of other mental disorders including bipolar disorder, major depression, obsessive-compulsive disorder, anorexia nervosa and borderline personality disorder.

Family support groups can provide respite from caregiving and help family members, including children, deal with their own feelings about the illness which may include grief, anxiety, guilt, resentment, shame, feelings of hopelessness and a desire to escape. They can normalize the experience for family members by explaining that treatment for mental illness is no different from getting help for any other physical ailment, says the CMHA. In addition, groups can help inspire and maintain hope by reminding family members that recovery is possible with the right kind of treatment and support.

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Wowk, Linda G., et al. *Who Turned Out the Lights: A Guide For Families Who Have a Relative with a Mental Illness*. Vancouver: Canadian Mental Health Association, BC Division, 1993.

Some Supportive Actions For Specific Mental Illnesses

Schizophrenia

- decide with your family member on appropriate routines and keep routines simple
- be patient about waiting for answers to questions: when the brain mechanism for thinking is not working as it should, answers may take a long time
- encourage maintenance of good personal hygiene
- give support and encouragement to help your relative feel more comfortable and included in social situations
- remember that if your family member is experiencing negative symptoms such as depression or apathy, they may wish to spend most of their time alone

Suicide

- all talk of suicide must be taken seriously
- tell the person you care by saying: "I don't want you to die" and "You are really important to me"
- phone your local emergency number

Eating Disorders

- take warning signs seriously; left untreated, eating disorders can become life threatening
- accept that it is frightening for the person to admit to having a problem that is out of control
- once the family member is in therapy, avoid discussing food behaviours or physical appearance; address concerns to the therapist, physician or both

Anxiety Disorders

- avoid quizzing, but encourage the person to write down his or her concerns including the demands made by family or work
- don't tell the person to "snap out of it"
- support and encourage the person to make certain lifestyle changes such as exercise programs, relaxation techniques and reduced intake of sugar, caffeine and nicotine

Depression

- listen to the person's concerns rather than giving advice on what to do
- do not tell the person to "snap out of it" or "cheer up"; this only increases the person's guilt and isolation
- be on the look out for suicidal thoughts or behaviours
- encourage the person to be more active and resume their previous responsibilities as they get better
- support the person in seeking help and making an appointment with a doctor and/or counselor

Manic Depression (Bipolar Disorder)

- try to discourage the person from becoming involved in heated discussions — a person who is in a manic state feeds on attention and conflict
- consider joining a self-help group for support and education; it can be extremely difficult to live with a person who is in a manic phase and refuses to see a doctor or refuses treatment.
- avoid arguing with the person when he/she is difficult to reason with because they can become aggressive

Aggressive Behaviour

(includes pounding fists, kicking walls, increased pacing, yelling, clenching fists, shouting insults)

- take all threats seriously: if at any time you feel threatened, leave the situation to protect yourself
- avoid touching and allow as much physical space between you as possible
- respond to questions with short answers so the person does not feel ignored, but do not answer questions that challenge you, for example, "You're too dumb to help"
- stay calm and try not to do any of the following: talk too fast or too loud, cross your arms, point your finger, stand with hands on hips or in pockets, shuffle your feet or fidget, make quick abrupt movements
- be prepared to call the police if necessary

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Getting Help for Mental Disorders

Perhaps the most important part of caring for one's mental and emotional well-being is knowing when and where to seek help.

Many people assume they can handle their day-to-day problems without spending much time dealing with their feelings, let alone reaching out to someone else for emotional support. But sometimes life throws a curve ball — a severe illness, a painful divorce or a sudden emotional crisis, for example — that depletes one's inner resources and leaves a person feeling helpless and overwhelmed.

The person may withdraw from friends and family, their work may begin to suffer or they may have trouble getting up in the morning. If these and other symptoms last for more than a few weeks, the person may need outside support to determine the cause of their low spirits and devise a strategy for improving their well-being.

Since everyone reacts differently to circumstances and events, the signs of mental or emotional distress may be obvious or extremely subtle. Some people live with mild depression for years without noticing that they lack energy and have trouble enjoying life as they did before. Other people may start to feel bad for no apparent reason at all. This is because some mental illnesses such as schizophrenia or manic depression can arrive with little warning. These illnesses are caused by biological or genetic factors that are sometimes completely unrelated to life events. Because emotions often change on a daily basis, many people have trouble distinguishing between the signs of mental illness and the normal ups and downs of life.

Michael Koo, 34, says he has had mild depression on and off for most of his adult life. During one period, he lost 15 pounds and became irritable and withdrawn to the point of not wanting to spend time with his four year-old child.

Nevertheless, Koo says it wasn't until he joined a co-op housing community that he realized he needed help. "I started clueing in that not everyone felt as flat as me," he recalls. Koo says he began to feel better once he took steps to end his isolation. "For me, depression is about not being in contact with other people."

Now he makes a point of reaching out to others for support whenever he feels sad, angry or overwhelmed. "I'll say to someone, 'I need two minutes where I can just really blow off steam,'" he says.

Family and friends are often the first to notice that something is wrong. Sometimes lending an ear to a friend or relative is enough to help the person get through a difficult period.

How Do I Know if I Need Help?

- I don't remember the last time I enjoyed anything
- I feel overwhelmed by my feelings of anger or despair
- I don't feel anything anymore
- I used to be healthy, but now I always feel a bit sick
- I eat a lot more or less than I used to
- My sleep patterns have changed
- I tend to wake up in a blue mood
- I've been missing more and more time from work
- I can't seem to go on since my friend/spouse/relative died
- There is so much conflict at home, I am afraid my marriage may break up
- I've been drinking heavily and/or using drugs to cope
- Sometimes I just want to end it all

Other times, the best thing friends and family can do is to express concern for the person and encourage him or her to make an appointment with a health care professional.

Even with the support of family and friends, the person may be reluctant to seek help. Common reasons include a belief that one should be self-reliant, distrust of health care professionals, fear of the shame and discrimination associated with mental illness and the notion that mental health treatments don't really work. For example, a 2003 Canadian Mental Health Association survey, for example, found that only one-third of Canadians are aware that new treatments for depression and anxiety are more effective, safe and tolerable, and only 12% believe that medication can actually help someone with depression or anxiety live symptom-free, as opposed to just cope better with their symptoms.

Early treatment is the key to restoring a sense of well-being and preventing the symptoms of mental illness from worsening over time.

There are many different kinds of support available. If you or a relative feels desperate and needs help immediately, you can call a crisis hotline number which is listed in the front inside cover of your local telephone book. You can also phone your local mental health centre or go to the emergency department of your local hospital.

Otherwise, a visit to the family doctor may be the best step to take. Your doctor can give you a thorough examination to rule out any physical causes for your mental health concerns. Then he or she may refer you to other sources of support such as a psychiatrist, psychologist

Sources of Assessment, Treatment and Support

- physicians
- mental health specialists
- employee assistance programs
- community mental health centres
- hospital departments of psychiatry or outpatient psychiatric clinics
- university- or medical school-affiliated programs
- family service/social agencies
- private clinics and facilities
- in addition to treatment, joining a support group may be helpful
- some people also benefit from treatments provided by alternative health practitioners, such as naturopaths or acupuncturists

or family counselor. These professionals can help establish a diagnosis and suggest an appropriate treatment plan.

Some people find it helpful to combine professional treatment with other forms of support such as a visit to a spiritual advisor, a community organization or a self-help group.

Self-help groups provide the mutual support of people who have similar experiences. These groups usually have a specific focus such as depression, child sexual abuse, eating disorders, panic attacks or some other mental health concern. According to the CMHA, many people benefit from witnessing signs of recovery in others and knowing they aren't alone.

People with mental health needs, their friends and relatives can learn more about mental health services and support by contacting one or more of the many community agencies listed below.

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Information Services Vancouver. *Red Book Online*. 33rd edition. 2002. Accessed 5 February 2003. Available online at www2.vpl.vancouver.bc.ca/DBs/Redbook/htmlPg/home.html

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Where to Get Help in BC

Mental Health Information Line

Free 24-hour automated system provides listings of mental health organizations and services in your community and recorded messages cover topics ranging from anxiety, bulimia and depression to family violence, schizophrenia and substance use problems. CMHA BC Division personnel staff the line from 9am – 4pm Mon-Fri; recorded information messages and voicemail are always available to callers outside these hours. Toll free in BC: 1-800-661-2121 (or 604-669-7600 in the Lower Mainland)

BC Healthguide

Information on more than 2,500 common health topics, tests, procedures and other resources is available to BC residents. This secure health database contains medically approved information from the Healthwise® Knowledgebase. Available online at www.bchealthguide.org

BC Mental Health Resource Guide

Online database of mental health services across BC. Compiled and maintained by UBC's Mental Health Evaluation and Community Consultation Unit. Available online at www.mheccu.ubc.ca/resourceguide

BC Nurseline

Health information and advice is offered through a toll-free telephone line. Staffed by registered nurses, the line is open 24 hours a day, 7 days a week. The service is also available for those who are deaf or hard of hearing, and translation services are available in 130 languages. Toll free in BC 1-866-215-4700 (604-215-4700 in the Lower Mainland, and 1-866-889-4700 for the deaf and hearing impaired)

BC Health Authorities

- Northern Health Authority
www.northernhealth.ca
1-866-565-2999
- Interior Health Authority
www.interiorhealth.ca
1-250-862-4200
- Vancouver Island Health Authority
www.vancouverislandhealth.ca
- Vancouver Coastal Health Authority
www.vancoastalhealth.ca
1-866-884-0889
- Fraser Health Authority
www.fraserhealth.ca
1-877-935-5669

Suicide prevention

Outside the Lower Mainland; crisis line numbers are listed in the Community Services section at the beginning of the White Pages phone directory. These lines can also direct you to your local mental health emergency services team.

- Vancouver: *The Crisis Centre*
604-872-3311
www.crisiscentre.bc.ca

Depression and bipolar disorder

- *Mood Disorders Association of BC*
support groups for people with depression or bipolar disorder, their family and friends. Call 604-873-0103 to locate a group in your area or www.mdabc.ca

Anxiety

- *Anxiety Disorders Association of British Columbia*
promotes the awareness of anxiety disorders and advocates for treatment programs
604-681-3400
www.anxietybc.com

Schizophrenia

- *British Columbia Schizophrenia Society*
provides support, public education, literature and information for people with schizophrenia and their families
604-270-7841
www.bcscs.org

Eating disorders

- *Association for Awareness and Networking Around Disordered Eating (ANAD)*
provides support for adult women with disordered eating, and their families
604-739-2070, toll free in BC: 1-877-288-0877
www.anad.bc.ca
- *Eating Disorders Resource Centre of British Columbia (at St. Paul's Hospital)*
an information, referral and educational service that works to address the problems of people with eating disorders and their families, friends and concerned health professionals
604-806-9000
toll free in BC: 1-800-665-1822
www.disorderedeating.ca

Alzheimer's disease and related dementia

- *Alzheimer Society of British Columbia*
provincial resource centre providing information and community support groups and services
604-681-6530 toll free in BC; 1-800-667-3742
www.alzheimerbc.org

Attention Deficit/Hyperactivity Disorder (ADD/ADHD)

- *Children and Adults with Attention Deficit Disorders (CHADD Canada Inc.)*
parent support group formed to better the lives of individuals with ADD and those who care for them. Provides family support, advocacy, public and professional awareness education
604-222-4043 (Vancouver Chapter)
www.chaddcanada.org (for a listing of other BC chapters)

Survivors of child sexual abuse

- *Vancouver/Richmond Incest & Sexual Abuse Centre (Family Services of Greater Vancouver)*
provides short term intervention and longer term counseling for sexually abused children, teens, their non-offending family members and adult survivors of sexual abuse
604-874-2938 (Vancouver)
604-244-9319 (Richmond)

Addictions

- *Kaiser Foundation*
works to assist communities in preventing and reducing the harm associated with problem substance use and addictive behaviours; produces and maintains the 'BC Addiction Information Online Centre' and the 'Directory of Addiction Services in British Columbia'
604-681-1888
www.kaiserfoundation.ca
- *BC Alcohol and Drug Information and Referral Service*
information and referral specialists respond to enquiries on all aspects of problem alcohol and drug use. They provide information on, and referral to, a variety of services including counseling services, detox centres, residential treatment centres and self-help groups.
604-660-9382 toll-free in BC 1-800-663-1441

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Getting Help for Addictions



Photo Courtesy: Health Canada

Substance use falls on a continuum based on frequency, intensity, and degree of dependency. The transition from use that may be "normal" to use that is problematic can be a slow, gradual process. Alternatively, problem substance use can occur more quickly, such as heavy drinking following a relationship loss, or increased dependence on pain medications following an accident. Addiction, the most serious level of substance use, is a disorder identified with loss of control, preoccupation with disabling substances, and continued use or involvement despite negative consequences.

The problems that can develop from substance misuse vary from mild to severe, and can involve a multitude of life functioning areas. Problems experienced from substance misuse can include immediate consequences such as a hangover following a night of excessive alcohol consumption. However, as substance use becomes more problematic, individuals can experience larger losses such as legal consequences, job loss, health problems, relationship problems or increased debt. How quickly the use of alcohol or a drug becomes problematic, however, really depends on the individual, their behaviour, and factors within the physical, psychological, economic, spiritual, social, and legal contexts.

What Do I Do If I Have a Problem With My Substance Use?

Getting help for a substance use problem can be scary. If you believe that you have a problem with your substance use, you are likely feeling scared already. It is important to recognize that you are not alone. There are millions of people across North America struggling with substance use issues, many suc-

cessfully.

It is important to recognize that you can get help at any point along the way, and the sooner you address your problems, the sooner you can create the life that you really want. Some important steps that you can take if you have a problem with substance use include:

1. Get honest with yourself! You know deep down on some level that your

use is a problem. It is time to be direct with yourself about this, so that you can address your needs head-on. The sooner you do, the easier it will be.

2. Challenge your fears! It is easy to believe that something is "wrong" with you, or that you are somehow weak, inadequate or

How Do I Know If I Have a Problem?

This simple questionnaire is useful for self-assessment in detecting dependency on drugs (including alcohol), and can be adapted for addictive behaviour as well:

- Have you ever felt you ought to cut down on your drinking/drug use?
- Have people ever annoyed you by criticizing your drinking/drug use?
- Have you ever felt bad or guilty about your drinking/drug use?
- Have you ever had a drink or taken a drug first thing in the morning to steady your nerves or get rid of a hangover?

One "yes" answer suggests a possible problem. More than one "yes" answer means it is highly likely that a problem exists. Additional signs that your alcohol or drug use is a problem include a continued increase in the amount of alcohol or drugs you need to consume to get the same effect, denial that there is a problem, an inability to remember events from nights when you were using, an inability to reduce your drug consumption, or a return to use after attempts to stop using. (Please note that this is only a guide and does not substitute for professional assessment)

Adapted from: Ewing JA. (1984) Detecting Alcoholism: The CAGE Questionnaire. JAMA, 252:1905-1907.



Photo: Courtesy of Health Canada

family member. Just sharing your issues with someone you trust can make it much easier to reach out for additional support.

4. Reach out and get help! There are a variety of resources and services available for persons wanting help with a substance use problem. You can find out what kind of help is available from your doctor, clergy or an employee assistance program (EAP). Therapists, community health agencies and alcohol/other drug treatment programs also provide valuable services.

sick because of your problems with substance use. These myths are not true. People use alcohol and other drugs to address a wide range of issues. It is important for you to discover yours.

3. Talk to someone about your problems and fears. You may want to involve someone close to you with your process, for additional support. This could be a spouse, friend, or

es. Additional resource information can be found at the end of this article.

Helping Someone Close to You With a Substance Use Problem

Substance use problems impact not only the person using, but others around them. Experience shows that for every person with an alcohol or other drug problem, at least four others are affected by their behaviour. Fre-

Helping

What to Do

- Talk to the person openly and honestly in speaking about their behaviour and its day-to-day consequences.
- Let the person know that you are reading and learning about problem substance use.
- Discuss the situation with someone you trust – doctor, clergy, a counsellor, a friend or someone who has experienced problem substance use personally or as a family member.
- Establish and maintain a healthy atmosphere in the home, and try to include the person in family life.
- Explain the nature of problem substance use as an illness to the children in the family.
- Encourage new interests and participate in leisure time activities that the person enjoys. Encourage them to see old, non-using friends.
- Be patient and live one day at a time. Try to accept setbacks and relapses with calmness and understanding.
- Refuse to ride with anyone who's been drinking heavily or using other drugs.
- Support the person's individual treatment choices.

What Not To Do

- Don't attempt to punish, threaten, bribe or preach.
- Avoid emotional appeals that may only increase feelings of guilt and the compulsion to drink or use other drugs.
- Don't set up unrealistic goals for yourself or the person.
- Don't allow yourself to cover up or make excuses for the person or shield them from the realistic consequences of their behaviour.
- Don't take over their responsibilities, leaving them with no sense of importance or dignity.
- Don't hide or dump bottles, throw out drugs, or shelter them from situations where alcohol is present.
- Do not give a person who is actively using money.
- Don't argue with the person when they are impaired or high.
- Don't try to drink along with the problem drinker or take drugs with the problem drug user.
- Do not attempt to direct or push the person's treatment participation.
- Above all, don't feel guilty or responsible for another's behaviour.

Source: Adapted from "If Someone Close...has a problem with alcohol or other drugs" by the National Clearinghouse for Alcohol and Drug Information



quently with problem substance use, it is family and friends who first recognize that a person's use of alcohol or other drugs has become problematic.

Initially a person who sets out to help someone with a substance use problem can feel alone, embarrassed, and uncertain about where to turn to for help. You may not have much information about substance misuse, or have misinformation, thinking of persons who misuse drugs as having a lack of willpower or moral weakness. It is important for you to gain some understanding about substance use so that you can be as effective as possible in supporting your loved one, as well as addressing the impact their use has had on you. It is important to understand that each person is unique – in their reasons for using alcohol or drugs, their reactions to these drugs, and their readiness for treatment.

While you are not responsible for their use or their recovery, you are in a good position to offer help and support, because you know their personal qualities and lifestyle well. Below are some do's and don'ts that may help you in addressing the substance use of someone close to you:

Where to Get Help in BC

Phone Resources

Alcohol and Drug Referral Service

- Information and referral service available 24 hours per day, 7 days per week. Referrals available to specialized addiction services, and also to a variety of community based resources. Toll free in BC: 1-800-663-1441. Lower Mainland: 604-660-9382

On-Line Resources

- *Kaiser Foundation's BC Addiction Information Centre:* addictioninfo.ca, contains a Directory of Services and a variety of resources

- *Prevention Source BC:* www.preventionsource.bc.ca, contains a variety of resources related to addiction, with a specific focus on prevention.

- *Canadian Health*

Network:

canadianhealthnetwork.com/!substance_use_addictions.html

- *My Room:*

www.aadac4kids.com, a kid's site

- *Zoot2:*

www.zoot2.com, a site for teenagers

- *You and Me Smoke-free!* www.hc-sc.gc.ca/hecs-sesc/tobacco/youth/index.html, an anti-smoking site from Health Canada, aimed at youth

Self-help Organizations

- *Alcoholics Anonymous (AA):* Organization of self-help groups throughout the world to support people who have an alcohol misuse problem. (250) 383-0415, email at: intrgrp@telus.net, www.alcoholicsanonymous.org
- *Narcotics Anonymous (NA):* Narcotics Anonymous is an organization of self-help groups throughout the world for people who have substance misuse problems. www.na.org
- *Cocaine Anonymous (CA):* Organization of self-help groups throughout the world to support people who have a cocaine misuse problem. Lower mainland website: www.ca-bc.org or www.ca.org
- *Adult Children of Alcoholics (ACOA):* 12 step group for persons born or raised in an environment where substance misuse was present. 604-222-1605 (24 hours) or www.adultchildren.org
- *Al-Anon:* A companionship of relatives and friends of alcoholics. Central Services and Lower Mainland: (604) 688-1716 or www.al-anon.org
- *Alateen:* A companionship of teenagers and young adults whose lives have been affected by someone else's drinking. Central Services and Lower Mainland: 604-688-1716 or www.alateen.org
- *Nar-Anon:* For family and friends of people with drug problems. For information on groups in BC: 604-878-8844, email at: naranonbc@hotmail.com or www.na.org